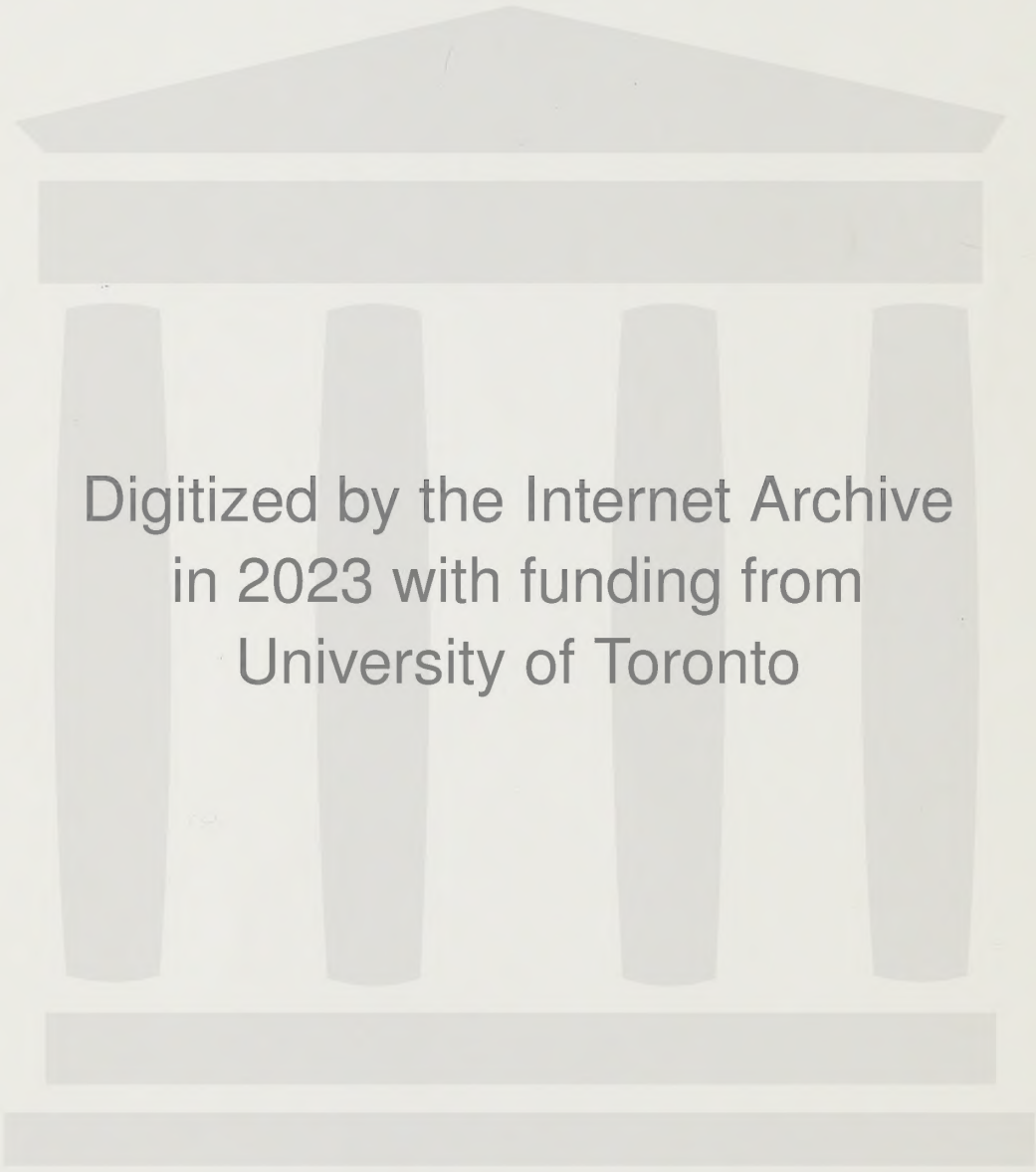
June 1966 to
December 1969

Report on the Activities of the Ontario Council of Health

Ontario Department of Health
Honourable Thomas L. Wells, Minister



REPORT OF ONTARIO COUNCIL OF HEALTH

ONTARIO

REPORT

ON THE ACTIVITIES OF

THE ONTARIO COUNCIL OF HEALTH

JUNE 1966

to

DECEMBER 1969

ONTARIO DEPARTMENT OF HEALTH
Honourable Thomas L. Wells, Minister

Produced for the
ONTARIO COUNCIL OF HEALTH
by the
COMMUNICATIONS BRANCH
ONTARIO DEPARTMENT OF HEALTH

MEMBERS OF THE ONTARIO COUNCIL OF HEALTH

K. C. Charron, M.D., LL.D.	Chairman of Council, Deputy Minister of Health
S. W. Martin, F.C.I.S., F.A.C.H.A.	Chairman, Ontario Hospital Services Commission
Miss C. Aikin, R.N., B.A., M.A.	Dean, School of Nursing, University of Western Ontario, London
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T. L. Jones, D.V.M., M.Sc.	Former Dean, Ontario Veterinary College, University of Guelph

J. D. Lovering, M.D.	Medical Director, Gulf Oil Canada Limited, Toronto
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J. F. Mustard, M.D., Ph.D.	Professor of Pathology, Faculty of Medicine, McMaster University, Hamilton
G. W. Phelps, B.Sc.	Orillia
H. Simon	Regional Director of Organization (Ontario), Canadian Labour Congress, Toronto
F. A. Wilson, Phm.B.	Vice-President, Parke and Parke Limited, Hamilton

Former members:

R. M. Anderson, B.A., M.D., C.M. (Resigned August 1968)	Director, Medical Care Unit, Queen's University, Kingston
Rev. H. L. Bertrand, S. J., L.Ph., L.Th., Ph.D. (Resigned June 1967)	Vice-President (Administration), Laurentian University, Sudbury
N. R. Richards, B.S.A. M.S., D. Sc. (Resigned June 1967)	Dean, Ontario Agricultural College, Guelph
Mrs. R. E. Smart (Resigned August 1968)	Brockville

Note:
Members are appointed on a three year rotational basis and are eligible for reappointment.

ONTARIO COUNCIL OF HEALTH

THE HEPBURN TOWER
QUEEN'S PARK, TORONTO
TELEPHONE 365-5031

February 1, 1970

The Honourable Thomas L. Wells
Minister of Health
Province of Ontario

Mr. Minister:

As Chairman of the Ontario Council of Health, and on behalf of the members appointed, I respectfully submit to you our report on the activities of Council from its formation on June 16, 1966, to December 31, 1969.

Yours sincerely,

K. C. Charron

K. C. Charron, M.D., LL.D.
Chairman

The senior advisory body on health matters
to the Minister of Health and the Government of Ontario

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Annexes to this Report
are to be issued
as separate volumes

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FOREWORD

The Ontario Council of Health is the senior advisory body to the Minister of Health and, through him, to the Government of Ontario on matters pertaining to comprehensive health services for the people of Ontario. For this purpose "comprehensive health services" is a broadened version of the World Health Organization definition for "medical care" and is as follows: "a programme of services that should make available to the individual and thereby the community all facilities of medical and allied sciences necessary to promote and maintain health of mind and body. This programme should take into account the physical, social, and family environment, with a view to the prevention of disease, the restoration of health and alleviation of disability. It includes the education, the training, and the research required to sustain these services. The extent of the services will vary with local conditions."

Although Council recognized the broad nature of the mandate it was given, it was aware also that other on-going investigative and reporting bodies were active in the health field—for example, the Task Forces in the Public Health field, those involved in the review of Mental Health care programmes, and subsequently the special committee studying Health Care Costs. In view of this, Council decided to concentrate mainly on other important areas in the health field and to establish Committees to investigate and report in these areas. This, together with the open-ended nature of the role it was given, the wide range of subjects that have been studied, the degree of completeness of reports in relation to the size and complexities of the subject areas assigned to Committees of Council, and finally the need for Council to take into account the interaction and relations of recommendations received from the separate Committees, makes it difficult to present a balanced and comprehensive overview of the work that has been accomplished in the total health field.

In spite of the difficulties of drawing together a comprehensive report, it is recognized that, in the complex field of health services, a wider dissemination of the work to date of the Council of Health could help to concentrate the efforts of those involved in planning, organizing, and providing health services in Ontario. The report has been prepared and organized to serve this purpose.

An abstract is provided to give, in summary form, an overview of the main trends of the recommendations in the reports that have been adopted by Council. A description of the organization and procedural arrangements of the Council gives further insight into the role it performs. Summaries of each major report reflect the main direction of recommendations in a specific area within the broad spectrum of health services. A listing of all the recommendations contained in the major reports of the Committees of Council completes this volume.

Separate volumes for each major report prepared by the Committees of Council will be issued as Annexes to this report. These Annexes will show the basis for the recommendations that have been brought forward.

ACKNOWLEDGEMENTS

The Ontario Council of Health is very much indebted to a large number of citizens of the Province who have given unstintingly of their talents and time for the purpose of developing a comprehensive health programme for their fellow citizens. Those who have participated directly as members of committees or have made contributions to individual reports are listed in each Annex. In addition, we wish to acknowledge the contributions by those whose behind-the-scenes efforts, as colleagues of committee members in other spheres or as their supporting staff, have added greatly to the value of the work of the Ontario Council of Health.

Abstract

ABSTRACT

PURPOSE

The purpose of this abstract is to provide a brief description of the role and functions of the Ontario Council of Health and to give an indication of the main trends for the future contained in the committee reports that have been adopted by Council.

THE AIM OF THE ONTARIO COUNCIL OF HEALTH

The Ontario Council of Health was formed to advise the Minister of Health and, through him, the Government of Ontario on the requirements of comprehensive health services for the people of Ontario.

GUIDELINES TO INVESTIGATIONS

One of the guidelines influencing the work of Council is provided by an extract from The Royal Commission on Health Services in the study of Organized Community Health Services which described the national health services situation as follows:

> *Scientific, social and economic changes are making the traditional pattern of separately developed and administered community health services less and less efficient. Circumstances have combined to create a rapid proliferation of health services of ever increasing complexity. The resultant overlapping service in some areas, gaps in services in other areas, and uneconomic use of skilled personnel and complex facilities are hampering the ultimate objective of providing a balanced pattern of modern community health services which work together effectively. Segregated community health service, planning and administration should be ended.*

This conclusion was one of the factors which led to the formation of the Ontario Council of Health and is the backdrop for studies to alleviate present shortcomings and chart the way for the future in the health field.

Also, the Ontario Council of Health is deeply conscious of the need for a societal and economic balance in the level of resources deployed against health care objectives. Council appreciates that in recent years the increasing public demand for health services of high quality, the quickening pace of medical/scientific advance, the growth of specialization, and the impact of inflationary factors on the price level of manpower-intensive personal services, have jointly occasioned a disproportionate increase in health care expenditures. The urgent need is recognized for health care patterns and operational practices which translate into expenditure levels compatible with the resource capabilities of the Province.

The requirement to identify and capitalize upon opportunities to achieve more efficient, economical, and effective use of human, physical, and financial resources is consistently applied to the work of Council.

METHOD OF WORKING

The method of working can be described as the pooling of the wisdom and experience of the members of Council, the members of the committees and sub-committees of Council, and experts in various fields who have made contributions to one or several of these bodies. Council selects the major areas of the total health system and forms committees to study and make reports in each of these areas. The reports are reviewed by Council, using the above-mentioned guidelines to investigations, and after full discussion a position of Council is indicated. Full or limited approval is given on the basis that Council can adopt a modified position if the influences of other reports received warrant such a change when the work is considered in a broader context.

With respect to health care expenditures, the Council had endorsed the creation of the Ontario Committee on Health Care Costs and the arrangements which have been made for the critical examination, by its task forces, of major areas of health care expenditure. In its capacity as the senior advisory body on health matters in the Province, Council looks forward to receiving the reports of the Committee on Health Care Costs and the opportunity to use this advice to support health patterns and practices serving to improve the effectiveness of health care expenditure.

As reports by committees increasingly incorporate subject matter having relevance to priorities and phasing, Council will give due

emphasis to cost benefit considerations and financial implications of each stage of development.

PRESENT STATUS

The Ontario Council of Health has an on-going role; therefore, this publication does not represent the completion of a task or any particular part of the task. Seven major reports have been received from committees and two from sub-committees of the Committee on Health Care Delivery Systems. These have contained recommendations of major importance, and work has proceeded to a point where it is possible to provide a broad summary of what has been accomplished to date.

ORGANIZATION OF HEALTH SERVICES

The requirements of future health services clearly point to the need for new administrative and operational organizations. The principle of organizing health services on a regional basis, as recommended by the Committee on Regional Organization, has been strongly supported by other committees. The acceptance of this concept should have wide-ranging effects on present administrative and operational arrangements. At the provincial level, department, division, and agency roles may require adjustment to plan, guide, co-ordinate, and evaluate the functions of the regions. Legislative and financial provisions for present programmes may ultimately require substantial change. At regional and district levels, which are new, the administrative and operational requirements of arranging the total health services of those jurisdictions have still to be designed and tested. Nevertheless, these arrangements hold much promise in providing health services which are more efficient, economical, and effective, than those presently used. The Ontario Council of Health endorses this concept and is continuing to study methods of implementing this type of health services organization for Ontario.

PLANNING FOR HEALTH SERVICES

The need for co-ordinated and comprehensive planning at all levels has been established. At the provincial level, the major role is seen as that of designing the framework of the health services in Ontario. This involves setting provincial objectives, setting guidelines and standards, and developing methods of evaluation. In contrast to centralized policy planning, detailed planning at levels below provincial level is seen as assuming a much more significant role. This

concept for the future will allow much more flexibility at the local level and thus capitalize on the integration of particular situations of smaller jurisdictions in the attainment of the goals set by the Province. The Ontario Council of Health endorses this concept of planning for future health services.

CO-ORDINATION OF HEALTH PROGRAMMES

The co-ordination or integration of all programmes concerned with the health of the population is a requirement of the future. This view, strongly supported by all Committees of Council, envisages programmes designed to operate collectively in furtherance of the broad aim of providing comprehensive health care for the people of Ontario. Within the guidelines and standards set by provincial authorities, co-ordination and integration of all but a few services is seen as being most effectively achieved on a regional and district basis. It is recognized, however, that certain specialized functions can logically only be provided for on a province-wide basis. The complexities of bringing together the wide variety of vital programmes presently provided by voluntary agencies, private enterprise, and public agencies, is seen as being possible only when they are directly associated with meeting the demands of local situations. The Ontario Council of Health endorses the trend of bringing all health programmes into a relationship where they collectively support the common broad health aims of the Province of Ontario.

PROGRAMMES OF HEALTH CARE SERVICES

Within individual programmes associated with health, recommended changes have produced some overall trends. A shift of emphasis, from institutionalized care at several levels towards more non-institutionalized care on an ambulatory or home care basis, appears to hold promise for the more effective use of present hospital services. Bringing into the mainstream of health services those branches of medicine and special programmes that are currently operated on a separate basis, such as mental health, rehabilitative services, alcohol and drug addiction services, is also foreseen for the future. The programmes for care of older citizens with their large medical, health, and welfare content, generally dealt with separately or in a manner inappropriate to the patient's needs at present, must also be brought more directly into the full spectrum of health care. Finally it is recognized that access to and movement amongst the levels of care appropriate to the individual's needs must be developed if health services are to be effective throughout the province. The Ontario

Council of Health endorses the indicated trends with respect to developing programmes which, collectively and working in close co-operation, will provide the high standard of health desired for the people of Ontario.

FINANCIAL SUPPORT OF HEALTH SERVICES

Financial arrangements for the support of health services must be such that they complement the trends of co-ordination and integration of all services within the health field. The trend established in the reports of the committees of Council supports the need for more flexible funding arrangements. The adoption of funding mechanisms which will reduce any gaps or grey areas of responsibility in provision of services, and which can be used to encourage the introduction or trial of innovative comprehensive programmes, is required. Similarly, for the individual, insurance arrangements should incorporate features which provide incentives for the effective use of health services. Also there should be no impediment to the entry or free-flow of the individual amongst the services available so he can receive care appropriate to his need. The Council of Health endorses the trends indicated for the financial support of health services.

INFORMATION FOR HEALTH SERVICES

To move towards the goals of a future health service, policy makers, planners, researchers, and operational managers must have access to accurate and up-to-date information. This is a common theme in all reports thus far received by Council. The Committee on Health Statistics made recommendations concerning a health statistics system in Ontario, based on data of adequate quality. A wealth of information produced by a large number of agencies is now available in Ontario and provides an excellent base on which to build a system. A future system should enable co-ordination and efficient gathering of sound and meaningful statistical data, and processing and storing information in usable forms. Access to the data bank would be possible at identified points of requirement. The system, using various techniques, including computers, would provide the data needed for the identification and surveillance of major health problems, effective and efficient operation and evaluation of health services and programmes, epidemiological research, health surveys, and special studies. In addition to linkages within the provincial system, a tie-in with a national system is foreseen. Provisions to protect the privacy of the individual will be included in the design of the system.

The Ontario Council of Health endorses the requirement for an information system for health services.

THE PRODUCTION AND DEPLOYMENT OF HEALTH MANPOWER

In the future, health services will continue to be a manpower-dominated service; therefore, the quality of the service must depend substantially on the quality, quantity, and balance in the supply of health manpower available for deployment in Ontario. Production of the manpower required is a most complex problem with many inter-related elements, of which some of the major ones are: the determination of the type and number of each category of health worker; the education and training of each category and the appropriate setting for this vital function; the close relationship of teaching, research, and service in the health field, and the need for health manpower to keep abreast of scientific and technological advances on a continuing basis, in an environment of rapidly increasing knowledge. Despite these complexities, all committees have made recommendations concerned with manpower production and deployment, in addition to those of a more specific nature made by the Committee on the Education of the Health Disciplines and the Committee on Health Manpower. From these, certain trends have emerged.

University health sciences centres are seen as having the role of bringing together those faculties charged with the education and training of health manpower in the university setting, and providing, in conjunction with the hospitals and an increasing number of other institutions involved in teaching and service, an opportunity for more beneficial research, particularly in the applied or clinical fields. The community colleges of applied arts and technology are seen as having a major role in the production of technicians in health fields. Together, through co-ordinated effort, these two types of educational institution, with the affiliated service institutions that provide clinical experience, are to be main sources of trained manpower for the health services of Ontario.

Many questions remain to be answered, such as the numbers required, the role, and the education and training of each category of health worker; however, it is accepted that the delivery of health care is such that the knowledge, experience, and leadership of a spectrum of disciplines and technologies are required in a variety of settings to accomplish the goal of effective service.

In addition to their role in teaching and research, the health sciences centres are also seen as being the focal points in the provision of service within their regions. The furtherance of this community role, in conjunction with their functions of teaching and research, and in association with local community colleges of applied arts and technology, is seen as a major factor in bringing the latest advances in the health field into the mainstream of service.

New methods in the delivery of health care, which maximize the productive use of various categories of health manpower, require investigation, trial by demonstration, and evaluation. Information so gathered will be invaluable as feed-back to the educational and training programmes, as well as providing valuable data for the continued effort to improve the effectiveness of health services through the efficient and economical use of health manpower resources. These are some of the main trends with respect to health manpower production and deployment that are endorsed by the Ontario Council of Health.

DEMONSTRATION OF HEALTH CARE DELIVERY

Many of the recommendations concerning the future delivery of health care are innovative and appear to hold great promise in providing high standards of service with reasonable cost. The complex nature of the services involved and the society they serve makes the introduction of a particular programme, on a universal basis throughout the province, a potentially expensive and high risk proposition. The use of demonstration projects is a method of overcoming these difficulties. The trend is towards this device, combined with operations research and scientific evaluation procedures, in testing the value and effectiveness of a programme on a limited controlled basis. This approach will, in addition, provide an opportunity to evaluate various essentially competing methods or concepts, and permit assessment on a more rational basis. The committees of Council have recognized the value of using demonstration models to test the programmes of promise in their areas of concern. The Ontario Council of Health endorses this method of testing and evaluating the effectiveness of a programme against specific criteria.

RESEARCH IN THE HEALTH FIELD

Trends in research follow several complementary and related lines. Basic research is required and must be supported, to continue the

probing for knowledge from which advances in science and technology find their beginning. In this area, no fundamental changes from present arrangements are seen. Applied or clinical research, being primarily concerned with the application of new knowledge and techniques to specific situations, is another line of research effort. Here, the more tangible evidence of scientific and technological advances can be seen. The trend for the future sees this type of research being primarily, but not necessarily wholly, within the sphere of the university health sciences centres and their affiliated hospitals. It is here that research and teaching have their strongest interface. Currently, there is increasing interest in that area of research concerned with social aspects of health and health care delivery. The trend here is to use the body of knowledge encompassed in the disciplines of social and behavioural science for the solution of the problems related to this area of health sciences. The Committee on Health Research has reported on the "Provincial Role in Health Research," and committees studying other fields have made recommendations on the essential role of research in the health field. The Ontario Council of Health endorses the trends indicated and strongly supports the need for a vital research programme that is in balance with the total health services in Ontario.

Report of the Council

CHAPTER I

The Role and Functions of The Ontario Council of Health

TERMS OF REFERENCE

The Ontario Council of Health was established in June 1966 by Order-in-Council, approved by His Honour the Lieutenant Governor. The responsibility it has as the senior advisory body on health matters to the Minister of Health and, through the Minister, to the Government of Ontario, was reaffirmed by legislative approval in *The Department of Health Act, 1968/69.*

Under this broad mandate the terms of reference of Council are:

1. *The co-ordination of health services with emphasis on co-operation and active participation of key agencies, associations and groups interested in health arrangements;*

2. *Techniques for long term planning, which are sufficiently flexible to accommodate short term projects and deal with urgent situations;*

3. *Priorities and phasing;*

4. *Health resources development and maintenance, including the health resources required for education and training, services and research;*

5. *Health manpower requirements;*

6. *Such other matters as the Council may deem to be pertinent to the objectives set out above;*

7. *Any specific subjects referred to the Council by the Minister of Health.*

In summary, the responsibility of Council is to advise the Government on the provision of health services to meet the health needs of the people of the Province of Ontario.

ORGANIZATION

Council is made up of 17 persons, with the Deputy Minister of Health as Chairman, and the Chairman of the Ontario Hospital Services Commission as a member. Other members are selected by the Minister: five from nominations by organizations of the primary health professions, five from nominations by public interest groups, and five chosen for their particular knowledge in health and health-related fields. It is intended that Council have balance with regard to expert knowledge, experience, and reasonable geographic distribution. In keeping with the continuing role of Council, members are appointed on a three-year rotational basis and are eligible for reappointment.

Council chose to direct attention to a number of major areas in the health field. This led to the establishment, during late 1966 and early 1967, of seven primary committees concerned with: health manpower, education of the health disciplines, physical resources, regional organization of health services, health research, health statistics, and library services.

An Executive Committee was given the overall responsibility of co-ordinating activities and advising on priorities and phasing. In addition, the Executive Committee has been given special assignments from Council and deals with urgent matters which may arise between meetings of Council.

The general requirements of the primary committees for knowledge on trends and elements of emerging health care arrangements, as a basis for projecting future requirements, led to the creation of the Committee on Health Care Delivery Systems, in 1968.

Committees of Council have initially immersed themselves in a definitive appraisal of their areas of concern. Assessments are then

made, through sub-committees, informal work groups, special presentations, selected studies, and field visits, resulting in conclusions and recommendations submitted for consideration by Council.

This committee structure has made it possible for an additional 60 persons to assist in the work of Council. With its various sub-committees, Council has been able to avail itself of the skills of more than 200 people. These men and women from across Ontario represent many occupational fields, such as education, business, and labour, as well as the health professions. Their willingness to serve and their high degree of participation reflect their interest in taking an active part in the development of provincial health programmes.

ON-GOING ROLE

Committees are expected to present a major report to Council at least once a year and it can be seen that each report represents innumerable man-hours of work. The reports are reviewed and acted upon at three yearly Council meetings. At these two-day sessions, Council also provides guidance to the committees and deals with any special tasks assigned by the Minister of Health.

As assignments are completed and new assignments taken on, the specific areas of concern of the various committees are modified accordingly. This trend is readily apparent in the diversification of sub-committees which are normally task-oriented. It is less pronounced in the primary committees which are subject-oriented and are related to the continuing function of Council.

The general approach of committees has been to bring forward recommendations of principle in their assigned subject areas. As these principles are endorsed by Council and accepted by the responsible Government authorities, the committees have then been asked to look into implementation aspects, where applicable. The current position of the various committees of Council is as follows:

Health Care Delivery: The arrangements for delivering health care determine essential requirements for manpower and education resources and physical facilities. New knowledge, population, health insurance, automation, and highly specialized techniques, are some of the changing factors affecting the way health care is delivered.

A major report on highly specialized services and an initial report

on regional laboratory services have been prepared. Council has also established sub-committees to study a rehabilitation system for the province, the role of computers in the health field, dental health services, and community health care. It is the intention of this Committee and of Council to consult with representatives of the health professions and related organizations, particularly in the important area of providing the best possible health services.

Health Manpower: Now that initial reports on medical, dental, and nursing manpower have been produced, this Committee is actively concerned with manpower requirements for the allied health disciplines and the family physician/first contact physician requirements.

Education of the Health Disciplines: The location and general arrangements for education and training of health workers are a primary concern of this Committee. It is attempting to develop general principles on such matters as recruitment, location, and extent of health worker training required for the health service needs of the province. Proposals for educational programmes as submitted to the Committee are considered in relation to provincial health services requirements.

Physical Resources: This Committee submitted a major report in June 1969, as summarized in this volume, and anticipates that Council will define its continuing task.

Regional Organization of Health Services: Following acceptance of the principles contained in the major report of January 1969, the Committee was reconstituted and is now considering approaches to the implementation of a regionalized system of health services.

Health Research: The Committee completed the task of recommending on a general policy for the provincial role in health research, in October 1969, and was discontinued. A new Committee was formed to assist in the implementation of this policy. The new Committee assumed responsibility to continue to review and assess applications for funding through the Provincial Health Research Grant. It also will be concerned with capital resources development related to health research.

Health Statistics: The Committee has reported, in January 1969, on the elements of a health statistics system for the province, and is now concerning itself with the organizational framework required to

implement the proposals.

Library Services: This Committee submitted a report in June 1969, on a proposed health information network to serve all health workers in the province, and is now concerned with the implementation aspects.

COUNCIL RESOURCES

It was recognized from the inception of Council that an inflow of information and suitable executive and technical support were essential requirements. As a consequence, a Secretariat was formed to provide administrative support and to assist in co-ordination. The Research and Planning Branch of the Department of Health was given the responsibility to provide technical support staff to committees, tapping resources both from within the Branch and from outside agencies as required. As well, other commissions, task forces, or study groups of Government or its agencies, have been at work on specific health and health related matters. Council, in its selection of work priorities, has taken note of these activities with a view to using the results of this work as they become available.

CHAPTER II

Summaries of Reports adopted by The Ontario Council of Health

SECTION I
Report by the Committee on the Regional Organization of Health Services
(See report of January 1969—Annex "A")

TERMS OF REFERENCE

The Committee on Regional Organization of Health Services was given the following terms of reference by Council:

> *Regional organization should be studied not only in its effect on health services, but also its relationship to other planning. The Committee should study the regional organization proposed by the Department of Economics and Development so that the health pattern might be considered in the light of other arrangements.*

BACKGROUND TO INVESTIGATIONS

Early in the Committee's deliberations, the desirability of establishing a system of regional organization of health services was accepted. This decision was based on the findings of the Royal Commission of Health Services and on other studies related to the principles of regionalization. A review was made of the concepts and purposes of regional organization, the involvement of the Province in regional organization to date, the existing patterns related to health

care in Ontario, and the experience in regional health planning and organization in other countries.

It also became evident, as the Committee proceeded with its task, that an analysis of the existing methods and procedures for financing facilities and programmes related to health care was necessary. This study revealed the complicated nature of the present financial situation, and suggested the need for financial arrangements which would facilitate regional development.

Underlying all the deliberations of the Committee was the principle that the system of regional organization developed should provide the most effective total health service for the people of Ontario.

With this background, the Committee developed a basic concept of a regionalized system of health services for the Province, and formulated recommendations of principle concerning the establishment of such a system.

RECOMMENDATIONS

There should be at least three levels of planning responsibility, including the Province. The province should be divided into regions and each region into a number of districts; regional and district councils should be established. Each region should contain a health sciences centre, which should have a positive role to play within the region. It is recognized that special arrangements might be necessary for northern Ontario.

Within this organizational structure, the Province should have overall responsibility for health services. Included would be preventive and curative services for physical, mental, and public health, but excluded might be those environmental control programmes which require some different type of geographic organization. The Province should delineate regions and districts, and be responsible for the overall planning and guidance for the provision of services, including the setting of policy, standards, and guidelines. It should provide selected specialized consulting services and should collect and analyse data for use in evaluating the effectiveness of the system. It should adopt financial arrangements which would facilitate regional development.

Regional councils should set goals for their regions based on

provincial guidelines, recognizing local needs and concerns. They should develop plans for the provision of services, programmes and facilities, and co-ordinate programmes to ensure that efficient, effective, and economic use is made of available resources. In collaboration with the Province, regional councils should evaluate the effectiveness of regional programmes.

District councils, within the framework of provincial guidelines and standards and the regional planning programme, should participate with the regional council in the planning process, maintain close relationships with the providers of health care, and co-ordinate the operations of organizations providing health care, to ensure a balanced, efficient, and economic service in the districts.

The Province should have an initial role in the development of a regionalized system. It should establish regions and districts, each region consisting of a number of districts. In the formation of districts, factors such as population density and distribution, distance, and regional government boundaries should be considered. A procedure should be established for the formation of regional and district councils. The councils should represent a balance of interest among the providers and consumers of health care, of local government, and of other related agencies and services. In addition, each regional council should have representation from each district council and the health sciences centre within its region.

The Province should be prepared to reorganize the agencies for which the Minister of Health is responsible, if this is necessary in order to ensure effective operation of a regionalized system.

It should also assess the financial implications associated with a regionalized system and adopt financial arrangements which would facilitate regional development.

ON-GOING ROLE

The Committee is currently carrying on investigations which will lead to recommendations concerned with the nature of a proposed system of regional organization of health services and with the phasing of its implementation. It is anticipated that the Committee will present a major report to Council in June 1970.

SECTION 2
Report by the Committee on Physical Resources
(See report of June 1969—Annex "B")

TERMS OF REFERENCE

The Committee on Physical Resources was given the following terms of reference by the Council:

> *This Committee would be concerned with the short- and long-term trends in the supply and demand for physical resources with a projection of future requirements. Two major areas have been identified, namely physical facilities needed for education, training, and research, and those required for service programmes.*

In their initial discussions, the Committee recommended that the words "supply and demand" used in the terms of reference be changed to "availability and need."

BACKGROUND TO INVESTIGATIONS

Early in the Committee's deliberations, it became evident that a definition of the health care delivery system was necessary, since physical resources must be responsive to changing needs and concepts of care. Although the development of such a definition was not within the terms of reference of the Committee, it did discuss such matters as the need for a system to take into consideration the continuity of care to patients, convenience and accessibility of care at all times, and the personalization of the delivery of health care. Throughout its discussions, the Committee kept in mind the goal of developing a balanced and dynamic system which would incorporate the features of efficiency, economy, and effectiveness, and which would include a method for on-going evaluation.

In addition, the Committee gave consideration to the development of a functional spectrum of health facilities in relation to the system of delivery of health services. This functional spectrum took into consideration services for the bedridden and the ambulatory patient, and incorporated the necessary progression in intensity of care and degree of patient mobility. It was used as a frame of reference by the Committee in maintaining a broad perspective and comprehensive

approach to all facilities required for the provision of a complete range of health services.

In this context, the Committee looked at the overall pattern or network of existing health services for the physically and mentally ill and at the individual components of this pattern. In addition, it looked at health facilities in relation to educational and research programmes, and at the planning, design, and construction of facilities.

The Committee drew conclusions concerning problems related to the present situation, and developed recommendations to alleviate shortcomings in the existing situation and to pave the way for the development of a future system.

RECOMMENDATIONS

The recommendations summarized first apply to all components of the existing pattern of health services and to the relationships among them, while others shown under the appropriate headings relate more specifically to the individual components.

Overall Pattern of Health Services

In order to facilitate co-operation and co-ordination in the planning of facilities and the establishment of policies governing the operation of programmes, the Province should establish a mechanism for co-ordinating the efforts along these lines of all the agencies involved in preventive and therapeutic services, physical and mental health services, public health and hospital services. The role of the Department of Health should be redefined to facilitate the planning and operation of services and facilities for the mentally ill within the context of general health services. Formal liaison mechanisms should be established, to co-ordinate activities of health and other agencies involved in the continuum of care. Among the departments involved would be Health, Social and Family Services, Education, Correctional Services, and Labour. To encourage local participation and better co-ordination locally, regional and district health councils should be established, and should be delegated appropriate responsibility and authority.

The methods and procedures related to the planning, operation and financing of health services should be co-ordinated and simplified. A functional spectrum of health facilities for patients in and ou

of hospital should serve as a frame of reference to encourage a broad perspective among those involved in co-ordinating, planning, operating, and studying individual types of facilities in the system for delivering health care. Within this spectrum, the levels and types of services which should be delivered in each facility should be defined, and shared services and co-operative working arrangements should be promoted. Mechanisms should be devised to ensure prompt transfer of patients to the appropriate facility.

Studies of institutionalized and non-institutionalized populations should be undertaken to determine what needs actually are for various types of programmes and facilities. This should lead to the development of new planning ratios and to new methods by which these are applied. Demonstration projects should be initiated on alternative possible ways of meeting needs and to test and evaluate new approaches to the delivery of health care. Studies should be undertaken to determine ways by which improvements can be made in the operational efficiency of all components of the health care delivery system. Present arrangements for financing the individual's care should be studied with a view to developing methods to insure a free flow of patients among the components of the system and to eliminate inappropriate use of facilities and programmes. Insurance and other mechanisms should be adjusted so as not to provide incentives for the use of unnecessarily expensive accommodation.

The Province should support a programme to standardize nomenclature of health facilities and programmes.

Active Treatment Hospitals

The process of planning for active treatment hospitals should be re-evaluated, with respect to incentives for responsible and innovative planning, and simplification of monitoring and approval techniques, and with respect to a restructuring of responsibilities within a regionalized system. Those who will have continuing responsibility for the operation of a facility should be involved in the planning process.

Active treatment hospitals should be considered as part of the functional spectrum of facilities for the community; only patients needing active treatment care should be treated in these facilities, and mechanisms should be established for prompt patient transfer. Utilization of beds now available should be increased by providing regular medical and diagnostic services on weekends, holidays, and in the evening.

Studies should be undertaken relating to the development and application of adequate planning ratios, to hospital operating efficiency, and to the provision of less costly alternatives to care in active treatment hospital. Until actual needs are more clearly defined, expenditures on conversion, renovation, and construction of new physical resources should generally be directed toward the provision of those facilities for which there appears to be a greater need and which are less costly to operate than acute care facilities (e.g. convalescent, chronic, ambulatory). Where small hospitals are ineffective and inefficient, they should be consolidated into a single unit or replaced with facilities for ambulatory care and support services.

Rehabilitation Services

Rehabilitation services should include social, psychological, educational, and vocational aspects as well as physical rehabilitation. These services should be provided throughout the spectrum of facilities and services and should not be separated from the general practice of medicine. Regional rehabilitation units, affiliated with health sciences centres and designed to serve in- and out-patients, should be established to serve as referral centres and to support the general rehabilitation units and voluntary agencies throughout the region.

Programmes and planning of Government departments and voluntary agencies concerned with rehabilitation should be co-ordinated by the establishment of an advisory committee, with the prime responsibility for co-ordination resting with the Minister of Health.

Convalescent Care Facilities

Appropriate facilities for convalescent patients should be provided in conjunction with active treatment hospitals. Studies should be made related to planning ratios, and of cost effectiveness, to determine which hospitals should have convalescent units. Early hospital discharge or transfer planning, and strengthened liaison among components of the spectrum of facilities for health and social services, should be promoted.

Chronic Care Facilities

More adequate provision should be made for facilities for the chronically ill, generally in association with active treatment hospitals, and widely distributed. Bed-population planning standards should be

revised. Professional patient assessment teams, in regional and district chronic care facilities, should serve local needs and act as referral centres to assess geriatric, physically and mentally chronically ill, and others, and to recommend their placement in appropriate programmes or facilities. Improved liaison and easy transfer of patients among the components of the spectrum should be promoted. Sections of provincial mental hospitals providing care for patients with both physical and psychiatric disabilities should be recognized in the same general category as chronic care hospitals, and service should be provided according to the same standards.

Nursing Homes

Long term provincial policies should be formulated related to extended care facilities and services, based on appropriate studies, with respect to such aspects as the roles of public, non-profit, and private agencies, and the problems of financing "intermediate" care to ensure that high standard nursing and related services are available to all who need them. Consideration should be given to the subdivision of licences based on level of service provided. The enforcement of nursing home regulations, licensing, and supervision should be strengthened and applied in a more uniform manner, and the Department of Health should support the upgrading of the training of administrative personnel. When regional and district health councils are established, planning for the provision of adequate nursing home facilities should be within their purview. In addition, formal co-ordinating mechanisms should be established, to be concerned with nursing home policy matters, and involving the Departments of Health and Social and Family Services and the Ontario Hospital Services Commission.

Homes for the Aged, Rest Homes, and Charitable Institutions

Formal, consistently used planning and co-ordination mechanisms should be established, involving the Departments of Health and Social and Family Services and the Ontario Hospital Services Commission, to achieve effective and comprehensive health care planning. Similarly, both health and welfare interests should be involved at regional and district levels in planning all types of extended care having a health care component.

Comprehensive Home Care Programmes

The current organizational pattern of home care programmes should

be reassessed, especially to provide advice on the desirability of comprehensive home care programmes being the responsibility of local Departments of Health. Co-ordinated home care programmes should be extended throughout Ontario and aided in reaching their full potential as quickly as possible.

Community Health Care Facilities for Ambulatory Patients

The Province should recognize the human value and the potential control over rising costs which would result from providing adequate health care facilities for those living in the community outside institutions (i.e. ambulatory care facilities). Health planning bodies at all levels should accept the concept that a co-ordinated network of health services and facilities can be complete only if services and facilities for ambulatory care are included. The Province should give priority to extending financial assistance to public and non-profit agencies for a range of ambulatory care services and facilities. Included would be renovated and revised hospital emergency and out-patient facilities, community health care centres to provide diagnostic and treatment facilities for groups of physicians, dentists, nurses, and other health workers, and community public health centres to provide service and educational facilities for organized community health activities.

Mental Health Facilities

Services and facilities for the mentally ill and the retarded should be planned, operated, and financed within the context of general health services. The role of the Department of Health should be redefined now, with a view to integrating psychiatric treatment services with other treatment services, and integrating activities designed to promote better mental health and prevent psychiatric disorders with the total effort of this nature of the Department. The financing of capital and operating costs for psychiatric and mental health services should be integrated fully with other health care programmes. Standards, indices, methods, and procedures involved in planning should be reviewed.

Psychiatric and mental health services should be integrated with the pattern of regional organization recommended for all health services. Boards should be established and made responsible for the operation of separate mental health facilities.

Efforts should be made to ensure that every general hospital is

able to care for psychiatric emergencies; psychiatric units in public general hospitals should be fully integrated with appropriate community services, and private practitioners of psychiatry using these facilities should be encouraged to provide community consultation services.

The facilities operated by the Alcoholism and Drug Addiction Research Foundation should be integrated with the mainstream of health services, education, and research.

Health Facilities in Relation to Educational and Research Programmes

Provision should be made in appropriate health care facilities for all levels of education of health personnel in programmes directed by universities, community colleges of applied arts and technology, regional schools, and hospitals. The current trend to bring together educational programmes for health professions in health sciences centres should be encouraged. The special clinical resources and higher unit costs of facilities accommodating clinical training and research programmes should be a recognized cost. Educational programmes for the health professions should be organized, in relation to the health services and programmes of the region or district in which the educational centre is located, and those responsible for health education should be on regional and district health councils. Clinical and operational research should be an integral function of all major health facilities used for teaching purposes; research space and equipment should be provided. The cost assigned for educational programmes should be limited to those components used for teaching and research which would not normally be provided in an institution with comparable responsibility for community health services. If no health sciences centres are anticipated soon for Northern Ontario, substitute arrangements for the needs of the area should be explored.

Sufficient capital funds should be made available now for the early development of health sciences programmes, in recognition of the many long-range benefits which will result.

Planning, Design, and Construction

For all categories of physical resources, the Province should develop guidelines and objectives for each level of planning. It should also adopt a more expeditious review and approval process. The Province

should create or assist in the establishment of a health facilities design and information centre. Pre-opening budgets should become effective during the planning of large and complex facilities and should include a large number of personnel who will have continuing responsibility for the operation of the facility.

ON-GOING ROLE

The future activities of the Committee on Physical Resources are now under review to define problem areas which warrant further investigation.

SECTION 3
Reports by the Committee on Health Manpower
(See reports of June 1968 and June 1969—Annex "C")

TERMS OF REFERENCE

The terms of reference given to the Manpower Committee at the inception of its task were as follows:

> *That this Committee concern itself with the short- and long-term trends in the supply and the demand for manpower with a projection of future requirements. A number of sub-committees would be required, dealing with individual disciplines or with an appropriate grouping. The Committee would need to establish a common methodology for manpower appraisals and emphasis would be placed on service requirements.*

BACKGROUND TO INVESTIGATIONS

In undertaking this task, the Committee decided to address itself initially to the three major health disciplines—medicine, dentistry, and nursing. Although the reports prepared were the result of extensive study and investigation, they represent simply the first stage in the examination of these disciplines. These studies were an effort to outline the broad parameters of the problem—existing numbers, university and school output, immigration, attrition, and comparisons with other countries and jurisdictions. From these factors were evolved tentative goals for the production of health manpower to keep pace with population growth and to improve the ratios of personnel to population. These goals were then translated into recommendations for the provision of further training facilities of certain kinds.

In studying the requirements for different categories of manpower, the Committee had to be aware that there are no definitive measures of absolute need or demand for service against which to measure the supply of doctors, dentists, or nurses. Likewise, in meeting any set estimated need, there is no one specific way of achieving this in terms of any one single category of personnel. The need for more medical service, for instance, might be met by the production of more doctors or by the development of assistants to doctors in order to increase the productive capacity of the existing

work force. The same principle applies to dentistry and nursing, where the dental hygienist and the registered nursing assistant are already important recognized categories of assistant health personnel. It was difficult in these initial stages to arrive at any fixed relationship between the primary personnel and their potential assistants, since this depends upon the voluntary co-operation of those concerned. Nevertheless, certain assumptions were made in this area, where possible.

The degree to which the Province relies upon immigration in the medical and nursing manpower fields was an area of extensive study by the Committee. Immigrant personnel perform a vital role in provincial health care systems and save the people of Ontario a vast amount of money in terms of instructional facilities and teaching costs. The problem is how or to what degree should the expected number of immigrant health workers be included in calculations of manpower production to meet projected requirements. This is further complicated by a not inconsiderable emigration of Ontario personnel, particularly to the United States.

Rates of attrition also received extensive attention from the Committee. This is a major problem, particularly in female areas of endeavour, such as nursing, where factors such as marriage and family formation create a large drain on trained personnel. Studies of female participation in the work force generally show that there is a rising proportion of women remaining in or returning to gainful occupation during marriage. This is a hopeful sign for the nursing work force in Ontario, and one that needs every encouragement through improvement in the working situation of the nurse.

RECOMMENDATIONS

Physician Manpower

The general philosophy of the Manpower Committee, in approaching problems relating to the supply of physicians, is based on the recognition of a number of basic underlying conditions, namely that great advantages could be derived from the application of scientific advances in the field of health—and that the current demand for services has outstripped the supply. It is further recognized that the capacity to deliver an improved quality of health care is dependent on new and more efficient systems of delivering health care, and that the future needs for physicians are inseparable from the future needs for members of the allied health professions, technologists and

technicians. It should also be recognized that an increasing proportion of doctors would enter teaching, administration, and research positions and would not practise.

The Committee is anxious that the Province reduce the dependence on medical immigration, both from other countries and other provinces. It is felt that existing faculties of medicine should be encouraged and provided with the means to expand their total admissions beyond the presently planned intake by as many students as are compatible with maintaining proper educational standards and available clinical facilities. New health sciences centres may also be needed. The conditions necessary for the operation of any health sciences centre are that it must be part of a multi-faculty university and be situated in an area of sufficiently large and dense population to ensure an adequate number of patients and doctors to participate in the educational programme.

The Committee considered that a new committee for the study of health care delivery systems should be established and that the study of this problem should be encouraged at universities. The Committee feels that research operations should be supported in the areas of group practice, community health centres, and the increased utilization of auxiliary health personnel. High priority should also be given to the study of assistants of various kinds to work with doctors. Economic involvement of doctors in the maintenance of hospital efficiency is also thought to be highly desirable.

Dental Manpower

In the field of dentistry, the Manpower Committee concludes that the general increase in the level of education, higher standards of living, and labour union policies, together comprise potent forces which the Committee believes could lead to substantially increased demand for dental services. The increasing scope and service of dentistry would be made possible by science and would be balanced approximately by the increasing professional productivity of the dentist with auxiliary personnel working under his supervision.

The Committee feels that the exact mix of dental and auxiliary dental manpower for Ontario must be gradually evolved. Auxiliary dental personnel must relieve dentists of many tasks so dentists may apply fully their knowledge and skills to solve problems which only they are qualified to undertake. The Committee feels that water

fluoridation and the topical application of fluorides should be extended. Dental programmes for school children and the social assistance group would bear heavily upon manpower needs.

The Committee concludes that educational facilities for the training of dental auxiliaries should be distributed throughout Ontario in order to encourage their employment in all parts of the province. Suitable agencies for the training of such personnel would be the community colleges of applied arts and technology, provided that suitable clinical resources are available in each location. A plan should be considered to encourage competent practitioners as teachers in these colleges.

A serious problem also exists in the provision of academic manpower in university dental faculties. The Committee feels that it is therefore important that dental faculties should be given every encouragement to expand their graduate and research programmes, because these are the sources of future faculty members without which the whole programme for increased provision of dental services cannot be carried out.

Nursing Manpower

In dealing with the problems of nursing manpower, the general approach taken by the Committee was to study the known factors such as supply, attrition, immigration, and current output programmes, and to evaluate them against the background of the health care delivery system. Because of their large numbers and their deployment throughout every facet of the health care system, no group is more greatly affected by the system than the nursing profession.

In the opinion of the Committee, the present programmes for the output of nurses appear to be entirely adequate for the next few years. Since the Committee has already recommended a study of the health care delivery system, in conjunction with its report on medical manpower, it feels that nothing more should be done to increase the output of nurses—aside from the completion of the current programmes—until such a system study is carried out. It might well be, for instance, that the orientation of future nursing programmes could preferably be directed toward community nursing rather than hospital nursing. The use of nurses in doctors' offices, for instance, might well be amplified in order to increase the number of patients that could be dealt with at that level.

The Committee is concerned with the high degree of attrition experienced in the nursing field—a reflection of the fact that it is a twenty-four-hours-a-day, seven-days-a-week profession—and an essentially female area of endeavour. If the level of attrition could be substantially modified through more flexible working hours and other measures, for instance, the need for future increases in nurse training facilities might be materially reduced

A further aspect of the nursing situation which held the attention of the Committee is related to the internal nursing organization within hospitals. It is felt that considerable room for improvement exists through the institution of various team nursing measures. In this way, staff could be more efficiently deployed and savings might be expected. This type of improvement has to be encouraged through the hospital administrations.

The organization of an incentive programme for all concerned in the treatment of patients—hospitals, doctors, and others—to encourage the diagnosis and treatment of patients on an ambulatory rather than a bedded basis, is a further major concern of the Committee. It is felt that every additional hospital bed requires its quota of nurses in order to service it, and if nurse training and operation costs are to be kept at a realistic level an approach along these lines will have to be taken.

ON-GOING ROLE

Many of the manpower areas in which the Committee has already submitted reports are subjects of continuing study. Many facets of nursing manpower still await clarification, as is exemplified by the continuing activity of the working sub-committee on nursing of the Education of the Health Disciplines Committee. In medicine, the study of the relative emphasis to be placed on the various specialities, as compared to general or family practice, remains to be resolved. In dentistry, the development of new types of assistant personnel, and the effect which this will have on numbers, is still a matter for debate. In addition to these, there are many other types of health personnel which the Committee has not yet considered in depth. The study of these further groups will provide much food for future discussion and study.

SECTION 4
Reports by the Committee on the Education of the Health Disciplines
(See reports of June 1968 and June 1969—Annex "D")

TERMS OF REFERENCE

The Committee on the Education of the Health Disciplines was given, at its inaugural meeting in the Fall of 1966, the following terms of reference:

> *To recommend on the location and general arrangements for the education of the health disciplines.*

BACKGROUND TO INVESTIGATIONS

The type and scope of the problems with which educational institutions have to deal in considering education of the health disciplines are legion and many organizational arrangements—both within and without the institutions themselves—seek to help solve these problems. The past few years have seen the setting up of health sciences centres in five universities of Ontario—University of Ottawa, Queen's University, University of Toronto, McMaster University, and University of Western Ontario. This consolidation of faculties for health sciences programmes allows basic departments of the biological and social sciences to serve the needs of each of the health professions. Also a sharing by the professions of expensive core facilities for patient care, the teaching hospital, and ambulatory care may be better achieved.

The establishment of the community colleges' programme has opened new possibilities for the education of health workers at the post-secondary level. These new institutions have a requirement for clinical resources to be locally available for teaching purposes. Further, for many health occupations, the community colleges require close working relationships with, and proximity to, university health sciences centres.

To utilize appropriately these two distinct types of educational institution, the required level of preparation for the occupation in question must be determined: degree or diploma. The Committee recognized that, for the health occupations, different levels of

preparation are required. Indeed, the crucial factor in recommending locations and general arrangements for their education and training is that of determining which level is indicated. Where there are instances of a particular discipline which has two or more levels of preparation, the matter is further complicated.

In addition, provincial health services require technicians in increasing numbers and, to meet these demands, hospital schools, technical schools, and vocational institutes are expanding. As above, for other levels of preparation, the problems here revolve around the choosing of appropriate locations for the training of technicians.

What is called for is recognition by universities, community colleges, hospital schools, and vocational institutes, as to the category of involvement for which each should assume responsibility, the extent of involvement of each institution when a health discipline calls for different levels of preparation, and the necessity to plan for the economic use of scarce staff and expensive clinical teaching facilities. Greater co-ordination in planning within the institutions, among the institutions, and between the institutions and government, is indicated.

There is an increasing complexity and variety in educational and training programmes for the health occupations. Branching and multiplication of training programmes for present health disciplines continue because of new practices in specialization, sub-specialization, and continuing education. Funding arrangements themselves are complex and require administrative mechanisms so that co-ordination can be achieved. To these variables may be added yet another of serious import for the foreseeable future: the patterns, or systems, of health care delivery in the 1970's and 1980's. New patterns or systems for the provision of health care services will surely rearrange mixes or compositions of groups or teams of health care workers, with attendant work modifications or role redefinition becoming mandatory.

In considering these matters, the Committee is endeavouring to advise on the greatest economic use of relatively scarce teaching personnel, facilities, and funds. There is a greater awareness of the need for government, in co-operation with institutions of education, to increase the benefits flowing to the public from—and to the graduates of—the new university health sciences centres, community colleges of applied arts and technology, and hospital training schools. There is also a vital need to apprise secondary school vocational

guidance counsellors of the latest information and trends in the provincial health field relative to careers in the health occupations. It is imperative that manpower decisions, on numbers and distribution of workers, be included in planning for education of the health disciplines. Regionalization should help to identify health services priorities and these will have an effect on district or local demands for personnel and facilities which, in turn, will have implications for educational planners within the region.

This then is the mosaic in which the Education of the Health Disciplines Committee must work. To do so effectively it has relied on information flowing from other committees of Council, visiting experts, departments of Government, professional and technical resource personnel, and the occasional site visit by Committee members. Further, the Committee has formed sub-committees to investigate the educational aspects of nursing, medical technology, laboratory technology and rehabilitation care.

RECOMMENDATIONS

Recognizing the complexities of educational matters, the Committee took an important step early in its work and presented the following basic principles to Council in 1967:

1. Programmes for education and training should be conducted within an education institution and a health service institution;

2. They should be based in the best and most proficient institute for each course;

3. They should be based on requirements for service, teaching, research, or administration;

4. They should be broad enough to enable a technician to move on to similar services in other locations;

5. They should provide some basis for advancement for competent graduates;

6. Students should be educated and/or trained to use their ability to full measure;

7. Techniques must be developed to determine the theoretical and practical knowledge required to carry out the work of each

category of auxiliary health workers;

8. Primary attention should be given to those who constitute a "health team."

Further developing these principles, the Committee recommended that, to insure rational origins of, or major alterations to, educational programmes, the skills and knowledge requirements of an occupation be accurately determined. As well, career profiles for occupations, once constructed, should materially assist in the understanding of educational patterns (basic and continuing) and the recommending of educational arrangements.

The Committee has sought to deal with the health occupations in terms of those groups of occupations which are responsible for delivering a block of health services, such as dental care services and rehabilitation care services. In this way, the Committee studied dentistry and its allied occupations and reported to Council on matters pertaining to the levels of education and the location of programmes of instruction for workers allied to dentistry.

Certain health disciplines work in a variety of settings, patterns, and arrangements, and therefore do not lend themselves to be studied in relation to one particular segment of care services. One such discipline is nursing. Although career profiles are far from complete, it has been possible for the Committee to study nursing in answering specific questions and to make recommendations pertaining thereto. In this regard, university schools of nursing should be encouraged to increase their capabilities, to improve recruitment methods, and to make post-basic baccalaureate and degree programmes more available. On another matter, the Committee also believes that the education and training of nurses to diploma level may be based in community colleges of applied arts and technology. Such a fundamental change, from hospital-based schools to colleges, will require phasing over time. The Committee also considers that team nursing studies should be undertaken so that work, social, demographic, and educational characteristics may be documented, the better to understand group functioning and to plan for the education and training of personnel.

The Committee has been studying the education and training requirements for physiotherapists. Identifying clearly a diploma level requirement, it considers that the community college in association with university health sciences centres and, therefore, adequate

clinical resources, is the appropriate location for the education of physiotherapists to this level.

ON-GOING ROLE

The on-going role of the Committee will include studies of those health occupations involved in delivering nursing, rehabilitation care and medical and laboratory services.

The complexities of dealing with educational matters relating to health care personnel are such that the Committee must obtain more complete information on the many variables identified earlier in this summary; much has been presented to Committee and much is in the process of development to the end that more definitive work for the future is anticipated.

SECTION 5
Report by the Committee on Library Services
(See report of June 1969–Annex "E")

TERMS OF REFERENCE

The Committee on Library Services was established in the spring of 1968 with terms of reference as follows:

> *This Committee would study all aspects of the library arrangements required for health services and the way the provincial programme would tie in with the national system, and possibly MEDLARS* in Washington. Consultant services would also be part of this arrangement.*

BACKGROUND TO INVESTIGATIONS

The Committee began its deliberations with an examination of available studies of health libraries in Ontario and in other North American areas. Selected health information science resources and health libraries were visited and a number of related agencies were asked to make presentations at Committee meetings.

On the basis of such findings, the Committee concluded that, as a first step, a broad network of health-related library facilities would have to be conceptualized consistent with service-related criteria.

As a consequence, the attention of the Committee was focused on the organizational requirements of a system which would provide a basic information service to provincial health personnel regardless of discipline, setting, or area of employment.

RECOMMENDATIONS

Proceeding to this objective and in respect of its terms of reference, the Committee on Library Services developed a proposal which would incorporate the following concepts:

1. Allow a health worker to make a single query which would capitalize upon the total retrieval capability of the system;

* Medical Literature Analysis and Retrieval System.

2. Provide a level of service such as to induce health personnel to make optimum use of the informational potential available;

3. Make available from the network sufficient breadth and detail of subject matter as to meet adequately the information requirements of the health community;

4. Enable a library of primary contact to process any query expeditiously, through the entire network if necessary, with sufficient reliability that users will not normally turn to alternative sources of information or bypass the network communication systems;

5. Incorporate regional concepts compatible with the principles outlined in the report of the Committee on Regional Organization of Health Services;

6. Encourage the development of regional resource centres through the appropriate expansion and integration of existing health sciences libraries;

7. Integrate into the system, where practical, the special health related library collections and services available within the province.

8. Provide an internal organization such that the capability of any component to answer a query can be promptly determined thereby avoiding unnecessary reference to higher information levels in the network.

In essence, the recommendations relate to four general topics: the role of major library resources as they presently exist; the establishment or strengthening of local health libraries; the development of a network co-ordinating mechanism; and a programme of basic and continuing education for medical librarians and medical library technicians. In its totality, the intent of the report is to assure the smooth functioning of the information network and the maintenance of standards. The Committee included guidelines as to the staff requirement associated with the various levels of the system.

The information network, as conceived, comprises an hierarchical structure of health related library resources. The basic component of the system would be in the primary contact library—the facility to

which health personnel would normally address information enquiries. Such units would have basic reference tools, adequate facilities, and the appropriate staff necessary to meet the service needs of the local health community. In addition, effective communication linkage would be established with other primary contact libraries and the regional resource centre. The nature and physical location of the primary contact library will be dictated by such factors as the numbers and discipline composition of local health personnel, their geographic distribution, and the degree of teaching and research to which they are committed.

A regional resource centre would serve as the focal point for all primary contact libraries located within the region. The modern communication network associated with such facilities would enable the peripheral primary contact libraries to capitalize upon the substantial information retrieval capability of the regional resource centre.

The responsibilities fulfilled by the regional resource centre would include the following:

1. Liaison and co-ordination both in respect of the internal regional information flow and the communication needs associated with the central resource;

2. Effective deployment of a field staff offering advice and assistance to the primary contact library to encourage the implementation of appropriate operational standards and methods, and to promote an advantageous utilization of the full network capability;

3. Development and control of practices designed to ensure the smooth flow of information and inter-library loans between all components of the network;

4. Availability of appropriate staff for the intra-regional components of the system.

An appropriate organizational component, having responsibility for provincial co-ordination, should be established within the Department of Health. Responsibilities at this level would include the following:

1. Liaison with federal level libraries such as the National Science Library;

2. Liaison with provincial associations, or provincial chapters of national associations, which have significant resource material;

3. Provision of consultative and advisory services to the network.

The Committee proposes that a Provincial Co-ordinator chair an operating committee, with representation from each region, which would include the Chief Librarian from each health sciences centre. A major function of the committee would be to facilitate integration of the regional resource centres into a smoothly functioning co-operative network.

The Provincial Co-ordinator would encourage private institutions or associations with special collections to participate, thereby expanding the scope of the network. The achievement of such arrangements would necessarily involve an appropriate supporting communication link between such collections and the health library network.

While the report stresses the organization and functions of a co-ordinated information retrieval system, it also notes the emergence of computer technology in select library settings within the province. The Committee endorses the phased implementation of practices which would capitalize upon this potential in respect of health library operational requirements.

Manpower requirements for the network are included in the report. Attention is directed to the shortage of qualified medical librarians having a life science background, and of library technicians with training in the particulars of health information processing and retrieval.

The report calls for an expanded bursary programme specifically oriented to providing the type of professional competence essential to network requirements. Assistance should be available to professional personnel in the health library system to attend training programmes and courses. The library schools should have a role in the provision of summer courses for degree programmes.

With respect to training technical personnel, recommendations include the following:

1. Having a health sciences centre librarian on the advisory committee for library technician courses at community colleges of

applied arts and technology;

2. Supporting those technicians seeking further training;

3. Providing courses on specific technical subjects such as reference tools in the health sciences.

ON-GOING ROLE

The Committee on Library Services has now turned its attention to the principles and techniques that may be involved in implementing a regionalized system for such a health information network.

SECTION 6
Report by the Committee on Health Research
(See report of October 1969—Annex "F")

TERMS OF REFERENCE

The Committee on Health Research was given the following terms of reference:

> *The Committee would advise on the co-ordination and development of the provincial effort in the field of health research.*

BACKGROUND TO INVESTIGATIONS

Health Research can be defined as:

> *All systematic study directed toward the development and use of scientific knowledge through fundamental research in laboratory, clinical investigations, clinical trials, epidemiological studies and engineering studies.*

Such research can be divided into three main components—biomedical research, health care research, developmental and applied research:

1. **Biomedical research** is defined as "health research in the following areas:

   a. The causes, diagnosis, treatment, control, prevention of, and rehabilitation relating to the physical and mental diseases and other crippling impairments of mankind;

   b. The origin, nature, and solution of health problems not identifiable in terms of disease entities;

   c. Broad fields of science where the research is undertaken to obtain an understanding of processes affecting disease and human well-being;

   d. Research in nutritional problems impairing, contributing to, or otherwise affecting optimum health;

   e. Development of improved methods, techniques, and equipment

for research, diagnosis, therapy and rehabilitation."

2. **Health care research** is defined as "the systematic inquiry into the need for, process of, and effectiveness of community health services."

3. **Developmental and applied research** is defined as "research specifically devoted to the application of existing knowledge to the solution of practical problems."

These divisions, however, should be regarded as a matter of descriptive and administrative convenience only. It is essential that those involved in all aspects of health research should engage in free and regular interchange of information and personnel.

In its deliberations, the Health Research Committee recognized that health research embraced a very broad spectrum of activity encompassing all aspects of biomedical research, a part in developmental research, and health care research. The Committee also recognized that health research was an important component of health education and health service, and in most instances could not be separated from these. The Committee therefore consulted as broad a group of individuals as possible in order to obtain information and advice on all aspects of health research. The report contains the results of these discussions and represents the opinion of the Committee and not necessarily that of the consultants.

The underlying principle of the report is that health research is a continuum and that all aspects are central for the development of effective health care, health services, and health education programmes. The fragmentation of health research, caused in part by different administrative and support programmes, should be resolved since it has resulted in underdeveloped areas of health research and has made it difficult to establish priorities. In order to establish priorities for both extra-mural and intra-mural research there is a need for an overall health research committee. The standards for health research should be the same in all areas. Because the Province has responsibilities in health care and health education, it is necessary that the Province ensure that health research should develop so as to be effective in respect to these.

RECOMMENDATIONS

For health research to be effective, the provincial role in health

research must be elaborated clearly and in detail. The provincial role in health research should be defined as "The provision of the facilities and resources necessary, in addition to those from federal and other sources, to achieve an integrated operation, in respect to the pursuit of fundamental knowledge and the application of this knowledge in the improvement of health, in the management of disease in the community, and in the assessment of the efficacy of health care."

The Province has a primary responsibility for the provision of health care and health education within its jurisdiction. Health research has major implications in both of these areas. It is essential that universities, communities, and government groups, have sufficient resources to provide a smooth interplay among the activities of health education, research, and service (patient care). The most rational approach to the allocation of resources for the provision of community health services is the establishment of priorities. Such priorities should be carefully determined on an objective basis.

To date, health research has been inadequately developed, supported, and co-ordinated. To overcome these problems and to achieve the objectives stated previously, it is essential:

1. That there should be adequate funds at various levels such as universities, communities, and government;

2. That allocation of all provincial funds for health research should be made on the recommendation of a representative review committee which has had the opportunity of appraising such arrangements for funds in the light of provincial needs; such a representative committee should report to the Ontario Council of Health.

A concept of rational financing of health research should embrace, among other important matters:

1. The allocation of capital funds for health research on the recommendation of a representative review committee;

2. The establishment of a mechanism for continuing collaboration among the Department of University Affairs, the Ontario Hospital Services Commission, and the Department of Health, to provide operating funds for health sciences centres;

3. A method of meeting salaries of full-time staff engaged in health research;

4. The development of suitable funding mechanisms to support staff engaged in research which has a significant education and/or service component;

5. The support of special groups of outstanding merit on the recommendation of a representative review committee.

In respect to independent agencies engaged in health research which are substantially funded from provincial sources, it is recommended that these should continue to be eligible to receive provincial grants for support of research.

Since a gap exists at present between the results of health research and its practical application, there is an urgent need to support applied and developmental research associated with health care in the province, to achieve co-ordination with other agencies which support programmes in health research, and to devise new training programmes and special funding mechanisms to improve the quality and extent of applied and developmental research.

Health research involves both a broad spectrum of disciplines ranging from fundamental sciences to applied technology, and also participation by community groups. Since health research is interdisciplinary, it is necessary to develop comprehensive graduate school programmes in the health sciences and to support interdisciplinary research and graduate study programmes among all the health disciplines and community groups.

To fulfil the provincial role in health research, it is essential to produce sufficient scientifically trained personnel, of whom at present there is a shortage. Therefore, it is part of the provincial role to encourage the training of individuals in health research and to facilitate and fund broad and flexible training programmes on an interdisciplinary basis in health sciences.

The principle of recognition of the interdisciplinary nature of health research should be carried into practice by extending the eligibility for research grants by the Department of Health to university departments and to community groups, other than those related to health sciences. Special recognition should be given to the importance of comprehensive research programmes on pollution. In

order to develop sound policies to reduce the hazardous effects of pollutants on health, an environmental quality committee of the Ontario Council of Health, made up of informed and interested persons, should be appointed to provide advice to Government on all matters related to the effects of pollution on health.

The concept of allocation of federal resources for health research on the basis of national interest, and the general scheme of funding by federal agencies, is recognized as advantageous. Nevertheless, in view of regional needs, specific community goals, and the continuing role of the Province in the inter-related areas of teaching, service, and research, there must be a strong provincial health research capability. Mechanisms should be established for the strengthening of co-ordination of provincial and federal research activities.

The provincial role in health research should recognize the need for the establishment of effective health research in health care and health services. This requires the establishment of techniques of measurement of the effectiveness of health care and health service programmes.

Hitherto, criteria for determining priorities in the provision of health services have relied to a great extent upon research into the perceptions of needs and actions by individuals or by health professionals. Well-meant enthusiasm for new techniques has often led to implementation of unproven, expensive programmes. Health care research should be directed towards assessment of the final results (end-results analysis) among patients who have received health care in experimental situations.

To achieve fulfillment of a policy of end-results and cost-effectiveness research, high priority must be given by universities to the training of personnel in the methods of epidemiology, biometrics, economics, and operations research. This process would be accelerated if there were established, both within health sciences centres in Ontario and within Government, a health service research capability which combines these disciplines. It should be emphasized, however:

1. That biomedical research, health care research, and developmental and applied research are inseparable;

2. That universities and the Province share responsibility for assessing and developing university programmes in education and research

relative to provincial health problems.

Because of all these considerations, the implementation of new health care and health services programmes should be based as much as possible on the results of health care and health services research programmes.

Finally it should be stated that the provincial role in health research should require the efficient integration of the planning, administrative, and financial operations involved in health research and the free and rapid interchange of information at all levels among health sciences centres, community groups, and government.

ON-GOING ROLE

The Committee on Health Research has the on-going task of reviewing and recommending the priorities for health research, of establishing co-ordination of the health research activity within and outside Government, of maintaining the standards of assessment of health research, and of developing the economics of subject matter relating to health research.

SECTION 7
Report by the Committee on Health Statistics
(See report of January 1969–Annex "G")

TERMS OF REFERENCE

The following terms of reference were given to the Committee on Health Statistics at its inception:

> *The objective is to develop a comprehensive and co-ordinated programme for health statistics for the Province. The Committee would explore this field and recommend arrangements which would provide selected information on a continuing basis as well as a capacity for the statistical analysis of individual projects. The various sources of information would be explored to determine potential as a source of statistics and the type of service which can be provided through such a statistical arrangement.*

BACKGROUND TO INVESTIGATIONS

Continued improvement in the provision of health care services in the province increasingly depends upon informed planning arising from well-developed research programmes. A prerequisite of both research and of the retinue of planning–development, operation, evaluation, and optimization–is the existence of a comprehensive and co-ordinated programme for health statistics.

The Committee addressed itself to the task of delineating those improvements which should be made to the present data base and which would facilitate data processing. By reviewing the literature, by listening to opinions of invited guests, by monitoring the deliberations of the other committees, by surveying the currently available sources of statistical information, and by drawing upon the experience of its members, the Committee developed this initial report to Council.

RECOMMENDATIONS

As a result of the Committee's deliberations concerning this aspect of a total statistics programme, the report covers a wide range of topics, which in the following summary are grouped under three general

headings. The first group of recommendations deals with items involved in rates, such as births, illnesses, and deaths, all of which serve to provide some measure of the task facing a health care delivery system. Committee recommendations in the second category include data on the availability, use, and costs of health services, which together provide a measure of the resources available to a health care delivery system. The area of interest encompassed by the third group of recommendations concerns methods whereby processing requirements could be improved in order to facilitate exploitation of files and of health related statistical data.

Data Related to Health Statistics Rates

Statistical rates, the common factor of the first set of recommendations, are necessarily based on characteristics of the general population. If, for example, rates from one area are to be compared with those from another, it is important to know accurately the size and composition of the population group in each area. The Department of Health should therefore seek appropriate access, where necessary for health investigations, to the files of the Census Division of the Dominion Bureau of Statistics. Similar access should be possible to census-type information gathered annually in conjunction with municipal assessment and filed by the Department of Municipal Affairs. The co-operation of the aforementioned agencies should also be solicited to the end that the population data base might be improved as needed for health statistics purposes.

Related to census data are projected population distributions used to forecast health needs in the province. Such population distributions are currently calculated by the Economic Planning Branch of the Department of Treasury and Economics. Inasmuch as their methodology and output format are consistent with the needs of health statistics, continued use should be made of these population projections.

Other recommendations in the first group relate to an ability to distinguish those segments in the population base whose exposure to risk may be different. Data pertinent to environmental factors and occupational exposures should therefore be collected and stored in systematic fashion so that they can be related to geographically relevant morbidity and mortality on the one hand, and to occupational health experience on the other.

The remainder of this first set of recommendations deals with

specific health related items which are frequently expressed as rates. They include foetal deaths, notifiable diseases, accidents, chronic disability, multiple causes of death, autopsy data, preventive procedures, occupational diseases, as well as family formation, characteristics, and dissolution. In some instances, data acquisition is not as complete as is desirable for the health needs of the Province. For example, it is current practice in Ontario that foetal deaths be registered only if the physician judges the event to have occurred during the twentieth week or later. The report proposes that all foetal deaths be reported regardless of the period of gestation. It is recommended that the Province re-examine the reporting system for notifiable communicable diseases to elicit any improvements that may be possible.

It is recommended that all classes of institution which provide residential care should provide statistics on those residents who are physically or mentally impaired. A mechanism should be developed to capture information on selected preventive and diagnostic procedures and special epidemiological studies should be launched to study health affects of specific occupational exposures to risk.

In order to capture information best obtained in the home setting, it is proposed that a continuous household sample survey be conducted in the province.

Health Resources

The report proposes that, in addition to hospitals and approved nursing homes, other institutions offering health services should provide suitable utilization data. In respect of manpower resources, the Province should collect adequate elementary data on health personnel. Insofar as deployment and utilization of both types of resources are concerned, ready access should be provided to data on availability, use, and cost of health services, supplemented where needed on a special study basis.

Processing Requirements

A number of methodological improvements that would benefit data processing and storage are presented by the Committee, including those dealing with linkage of files and with the associated need for a unique universal identification number. With respect to the latter requirement, use of the Canadian Social Insurance Number is recommended.

In the interest of obtaining accurate incidence rates based on numbers of new cases, the Province should promote arrangements to obtain, on claims for payment by hospitals and physicians, an indication of those diagnoses first established in the course of the medical care involved.

ON-GOING ROLE

The Committee is now directing its attention to subject matter related to the organization and the implementation of a health statistics programme.

SECTION 8
Report by the Committee on Health Care Delivery Systems
(See reports—Annex "H")

TERMS OF REFERENCE

The Committee on Health Care Delivery Systems was given the following terms of reference:

1. *The Committee will be concerned with the study and assessment of health care systems and arrangements as they exist in the Province at the present time and make appropriate recommendations where indicated for the modification of these systems or establishment of new arrangements;*

2. *It will identify health care arrangements which require priority for study and be responsible for instituting a review of these situations;*

3. *It will institute a broad assessment of the total spectrum for delivering health care, including education and research. In many circumstances this will be accomplished by bringing together the information which other primary committees of Council, agencies or associations have or might assemble;*

4. *This Committee, as a primary Committee of Council, should report directly to the Council.*

BACKGROUND TO INVESTIGATIONS

In view of the complex nature of its sphere of activity, the Committee delegated portions of its work to six sub-committees: Community Health Care, The Role of Computers in the Health Field, Dental Care Services, Highly Specialized Services, Laboratory Systems, and Rehabilitation Services.

The Sub-committees on Community Health Care, The Role of Computers in the Health Field, Dental Care Services, and Rehabilitation Services, are at various stages of deliberation in pursuit of their respective tasks. So far, they have not submitted recommendations or reports, but each has considered various matters associated with its sphere of work such as existing arrangements for delivery

of primary health care, the role of the family physician, the composition of primary health care teams, and factors affecting delivery of primary health care in the community (Community Health Care Sub-committee)—the development of a concept for a total health information system which encompasses patient care data, health statistics, and knowledge banks, and which could make appropriate use of computer technology (Computer Sub-committee) —prevention of dental caries (decay), fluoridation of water supplies, health education in preventive dental care, better distribution of dental manpower, training and retraining of dental hygienists and dental assistants, and dental care to special groups (Dental Care Services Sub-committee)—identification of groups requiring rehabilitation, the main course of handicapping conditions, the services required for prevention, diagnosis, assessment, and treatment of handicapping conditions and the organization of such services (Sub-committee on Rehabilitation Services).

The Sub-committees on Highly Specialized Services and Laboratory Systems have submitted reports which are summarized in the following sub-sections.

SUB-SECTION A
Report by the Sub-committee on Highly Specialized Services
(See report of October 1969—Annex "H")

TERMS OF REFERENCE

The Sub-committee on Highly Specialized Services was constituted:

> *To study and recommend on development of such services as organ transplantation and renal dialysis within the overall framework of health services.*

BACKGROUND TO INVESTIGATIONS

At the start of its task, the Sub-committee defined a highly specialized service as:

> *A diagnostic or therapeutic facility often directed toward one organ or disease, requiring a high level of professional expertise and/or sophisticated equipment not essential in each hospital but essential within regions of the province.*

The Sub-committee was conscious of the need to conserve and concentrate resources, including skilled manpower, and to provide and maintain skills at the highest level in the best interests of the patient. It also recognized that the elements of research and education were indispensable to the consideration of highly specialized services.

With these factors in mind, it then gave consideration to the types of services to be provided at the various levels of care—provincial, regional (or health sciences centre), district, and community.

Finally, the method of undertaking its task in a field which embraced the widest possible range of highly skilled expertise necessitated a broad canvass of leading university and hospital personnel and of agencies involved in the subjects concerned. In seeking such information, the Sub-committee approached authorities in other provinces and reviewed the situation in other countries.

RECOMMENDATIONS

The recommendations of the Sub-committee related to both distinct highly specialized services, such as open heart surgical units, and to traditional specialities, such as ophthalmology and otolaryngology, within which have emerged a number of related highly specialized supporting services or subjects. The following were considered in depth—open heart surgical units, renal transplantation units, haemodialysis units, neurological and neurosurgical units, otolaryngology, ophthalmology, paraplegic units, burns units, hyperbaric units, rheumatic disease units, clinical investigation units, gastro-intestinal units, radiotherapy units, radio-active isotope units, intensive care units, coronary care units, respiratory failure units, pulmonary function laboratories, genetic counselling, chromosomal analysis and metabolic screening, perinatal centres, learning disabilities, and cerebral palsy.

These recommendations set out guidelines concerning numbers, sizes, locations, and staffing of units in both highly specialized services and highly specialized supporting services within traditional specialities.

In addition, the Sub-committee felt that its task would be incomplete without consideration of four services—transportation services, hostel services, day care services, and social services—which, although not in themselves highly specialized, are of considerable importance in making possible the effective use of highly specialized services.

ON-GOING ROLE

The report of the Sub-committee on Highly Specialized Services is regarded as definitive at present. So accelerated, however, is the rate of advance in the application of scientific techniques in medicine that reconsideration of various aspects may be essential in due course.

SUB-SECTION B
Report by the Sub-Committee on Laboratory Systems
(See report of October 1968—Annex "H")

TERMS OF REFERENCE

The Sub-committee on Laboratory Systems was originally constituted under the Committee on Regional Organization of Health Services with the following terms of reference:

> *To study the advisability, feasibility and pattern for development of a regional system for providing laboratory services within a regional system for delivery of health care services, and to recommend a pattern for development of a plan which would be sufficient to allow further steps to be taken.*

BACKGROUND TO INVESTIGATIONS

The Sub-committee approached the task by applying its terms of reference to diagnostic and other laboratory services related to patient investigation and care.

RECOMMENDATIONS

The report of the Sub-committee on Laboratory Systems emphasizes the importance of developing integrated regional laboratory services to increase the efficiency of existing laboratory services, to provide an orderly framework for their expansion so that patients and practitioners alike may receive maximum benefit from available resources, and to make available a greater range of services to a larger proportion of the population.

It proposes that the core of each region be a grouping of laboratories with integrated and correlated services located at the regional centre, with due allowance for flexibility, changeability, expansion, and addition of new facilities, as services and developing technology demand. The organizational structure should be such that it could meet community needs at all levels including reference centres.

It also expresses the hope that the various regional programmes would be integrated into a comprehensive provincial programme.

ON-GOING ROLE

The Sub-committee on Laboratory Systems was reconstituted in April, 1969, under the Committee on Health Care Delivery Systems, to consider this report, to develop recommendations for implementation, and to propose and develop a provincial pattern of laboratory services. Currently it is actively engaged in fulfilling this task.

CHAPTER III

Recommendations submitted to The Ontario Council of Health

The recommendations in this chapter are those which are contained in the following reports:

Section 1	**Regional Organization of Health Services**	**Annex "A"**
Section 2	**Physical Resources**	**Annex "B"**
Section 3	**Health Manpower**	**Annex "C"**
Section 4	**Education of the Health Disciplines**	**Annex "D"**
Section 5	**Library Services**	**Annex "E"**
Section 6	**Health Research**	**Annex "F"**
Section 7	**Health Statistics**	**Annex "G"**
Section 8	**Health Care Delivery Systems**	**Annex "H"**

Readers should note that the recommendations in this listing are separated from the conclusions and complementary remarks with which they are associated in the reports. In view of this, reference to the reports is required for a detailed consideration of specific recommendations.

The Ontario Council of Health has adopted the majority of the recommendations listed; however, where there are important reservations, Council's position is indicated in accompanying notes.

SECTION 1
Recommendations by the Committee on the Regional Organization of Health Services
(See report of January 1969—Annex "A")

1. THAT the organization and development of the several inter-related health services be carried out on the premise of providing the best possible total health services for the people of Ontario within a regional organization.

2. THAT such regional health organization should be based, in general and where specifically applicable, on university spheres of influence and interest and that every reasonable means be taken to assure that the health sciences centres of these universities are capable of assuming an active dual role in education and research, as is their prime function, as well as in continuing education, re-training and service consulting in both the professional and semi-professional aspects of the total health services with which they may be totally or in part responsible.

3. THAT the implementation of a regional plan for total health service be based on at least two levels of authority and responsibility, the region and districts within each region.

4. THAT councils be established at the regional and district levels to exercise the authority and responsibility delegated by the Province.

5. THAT the Province have the role of providing policy guidance, of setting standards and of assessing the overall effectiveness of the system.

6. THAT the regional council have the role, based on provincial guidelines, of planning for the provision of health services within its region, to ensure that efficient, effective and economic use is made of available manpower, facilities and funds.

7. THAT the district council have the role, based on provincial guidelines and the regional planning programme, of organizing the provision of health care for the residents of the district, and of co-ordinating operational functions.

8. THAT a detailed study be made of methods of implementing a system of regional organization for Ontario.

SECTION 2
Recommendations by the Committee on Physical Resources
(See report of June 1969—Annex "B")

Overall Pattern of Health Services

1. THAT, in order to facilitate co-operation and co-ordination in the planning of facilities and the establishment of policies governing the operation of programmes, the Government of Ontario establish a mechanism for co-ordinating the efforts along these lines of all the individual agencies involved in preventive and therapeutic services, physical and mental health services, public health and hospital services, with a view to avoiding duplications, gaps, conflicts and inconsistencies. Such a co-ordinating group should be organized to be responsive to the varying needs of the consumers and providers of health care.

2. THAT services and facilities for the mentally ill and for the retarded be planned, operated and financed within the context of general health services, and that the role of the Department of Health be redefined now with a view to:

   a. integrating psychiatric treatment services with all other treatment services;

   b. integrating those activities designed to promote better mental health and to prevent psychiatric disorders throughout the province with the total effort of this nature in the Department;

   c. integrating the financing of capital and operating costs for adequate psychiatric and mental health services to provide comparable standards of care with other health care programmes. The same principles should apply.

3. THAT the Province establish regional and district health councils and delegate to these councils appropriate responsibility and authority. The responsibilities of these councils should include review of institutional plans in terms of area-wide objectives and appropriate encouragement of use of different types of facilities by the public, by the health professions and by those responsible for the administration of the health facilities.

4. THAT the methods and procedures related to the planning, operation, and financing of health services be co-ordinated and simplified.

5. THAT a functional spectrum of health facilities, as outlined in Figure 1 and Attachment 1, Appendix A (see report of June 1969), for the care of patients in and out of hospital serve as a frame of reference to encourage a broad perspective on the part of those responsible for co-ordinating, planning, operating and studying individual facilities in the system for delivering health care.

6. THAT, within the functional spectrum, the levels and types of health services which should be delivered in each facility be defined and that shared services or co-operative working arrangements among institutions be promoted where they may lead to more effective or economical deployment of health resources.

7. THAT studies be undertaken to determine ways by which improvements can be made in the operational efficiency of all components of the health care delivery system.

8. THAT formal liaison mechanisms be established to co-ordinate activities of health and other related agencies involved in the continuum of care, especially for those who cannot live independently. In particular, this would involve the Departments of Health, Social and Family Services, and Education.

9. THAT studies of institutionalized and non-institutionalized populations be undertaken to determine what current needs are for various levels of care, types of programmes and facilities, and that demonstration projects be initiated on alternative possible ways of meeting these needs to ensure that the new policies introduced will result in the provision of care in the most effective and economical manner.

10. THAT the studies indicated in Recommendation 9 be co-ordinated with a review of standards on which the planning of health services is based, and a review of the methods by which these standards are applied, with a view to establishing planning ratios more precisely related to levels of care appropriate to patient needs.

11. THAT the present arrangements for financing the individual's

care be studied, with a view to developing methods to ensure the free flow of patients among the components of the system, and to eliminate the inappropriate use of facilities and programmes.

12. THAT encouragement be given, and direct financial assistance be made available starting in the 1969/70 fiscal year, to public or non-profit organizations to develop experimental or demonstration projects concerned with new approaches to the delivery of health care. Provision should be made for careful evaluation of the operation of such programmes.

13. THAT the Province support a programme to standardize nomenclature of facilities and programmes related to health services at least in Ontario and preferably throughout Canada.

Active Treatment Hospitals

14. THAT the entire process of programme and project planning for active treatment facilities be re-evaluated, with respect to incentives for responsible and innovative planning and simplification of techniques for monitoring and approval, and with respect to the roles and responsibilities of institutional, community, district, regional and provincial authorities.

15. THAT encouragement be given to the involvement in programme and project planning at the local level of the health and administrative personnel who will have continuing responsibility for the operation of the facility after its completion, and that steps be taken to make available to these professional providers of care comparative operational and medical data for use in planning and management.

16. THAT the studies of a representative sample of institutionalized and non-institutionalized populations, recommended elsewhere in this report, be undertaken to determine what current needs are for various levels of active treatment care, and that careful analysis on an area-wide or regional basis be made of the alternative possible ways of meeting these needs (e.g., in an ambulatory or bed-related setting). These studies should lead to the development of new planning ratios, and of new methods by which these are applied.

17. THAT, until needs are more clearly defined (as a result of the studies in Recommendation 16), expenditures on conversion,

renovation and construction of new physical resources be directed, where practicable, toward the provision of those categories of facilities (e.g., ambulatory, convalescent and chronic) for which there appears to be a greater need and which are less expensive to operate than acute care facilities.

18. THAT, in districts where small hospitals are ineffective and inefficient, they be consolidated into single units or converted and used for a more appropriate level of health care. The acute care functions of the small hospitals might be replaced with facilities for ambulatory care and support services.

19. THAT studies be made relating to the provision of less costly alternatives to in-patient care in active treatment hospitals and that insurance and other mechanisms be adjusted so as to remove incentives for the use of in-patient care in active treatment hospitals while arranging for incentives for other types of care.

20. THAT studies be made of hospital costs to suggest ways by which operational efficiency and economy of hospitals can be improved. Included might be studies related to alternative payment mechanisms for services, to management practices which stress cost effectiveness, to the provision of incentives which reward high quality and economical practices by hospital personnel and to alternative methods for handling food, laundry, purchasing and other supporting services which might be shared advantageously by several institutions or eliminated from the hospital plant.

21. THAT utilization of beds now available in active treatment hospitals be increased by providing regular medical and diagnostic services on weekends, holidays, and in the evenings, recognizing the need to balance the increase in immediate operational cost against the long-term savings which would ensue from reduced bed requirements.

22. THAT acute care hospitals be considered as part of the spectrum of health facilities for the community and that a concerted effort be made to restrict admission or retention of patients in active treatment hospitals to those requiring the special services only available in active treatment hospitals and that mechanisms be established in the community to ensure the prompt transfer of patients to other types of facilities and services when they no longer require the services of an active treatment hospital.

23. THAT community hospitals of appropriate size and under certain circumstances make provision for medical personnel based full time on the premises to assist in the direction and administration of clinical services, to encourage better ambulatory and emergency services at the hospital, and to establish a base on site for urgent consultation and for continuing education. Accommodation for this purpose should be provided.

Rehabilitation Services

24. THAT the scope of rehabilitation services be defined to include social, psychological, educational, and vocational aspects as well as physical rehabilitation.

25. THAT the programmes and planning of the several governmental departments and voluntary health agencies concerned with the broad aspects of rehabilitation be co-ordinated by the establishment of a broadly representative advisory committee, with primary responsibility for co-ordination resting with the Minister of Health.

26. THAT general rehabilitation services be accommodated in active treatment, convalescent, and chronic disease hospital units, with emphasis on the extension of these services into the ambulatory, domiciliary, and home setting, and also on the avoidance of isolation of these services from the general practice of medicine.

27. THAT regional rehabilitation units to serve both in- and out-patients be established as centres for referral of patients with severe, prolonged or unusual disabilities, and to serve as a repository of specialized resources to be used in support of the general rehabilitation units of the region and the needs of voluntary health agencies. To facilitate educational and research programmes, the regional units should be affiliated with university health sciences centres.

Convalescent Care Facilities

28. THAT, in the future, appropriate facilities for convalescent patients be established in or in conjunction with active treatment hospitals. The provision of these facilities should be based on studies of the desirable overall ratio of convalescent beds to populations of varying compositions, of the crossover points of cost and effectiveness as between hospitals which should and

those which should not provide special convalescent facilities, and of the best way to provide such facilities in communities with more than one hospital.

29. THAT early hospital discharge or transfer planning, and strengthened liaison between appropriate components of the functional spectrum of facilities for health and social services, be promoted by regulation, through governmental consultative services, through voluntary accreditation processes, or by other means.

Chronic Care Facilities

30. THAT more adequate provision be made for special facilities for the chronically ill, generally in conjunction with active treatment hospitals, and that in the provision of chronic beds the social advantages of wide distribution of such facilities be kept in mind, subject to the maintenance of approved standards of activation and other services and to easy transferability of a patient between the community, district and regional levels.

31. THAT the sections of the provincial mental hospitals presently providing care for patients with both physical and psychiatric disabilities be recognized in the same general category as chronic care hospitals and service provided according to the same standards.

32. THAT revised bed-population ratios as planning standards for chronic care facilities (and related alternative facilities) be arrived at through studies, recommended elsewhere in this report, related to levels of care requirements of all segments of the population of Ontario.

33. THAT professional patient assessment teams be organized in district and regional chronic care facilities to serve not only the needs of the medical staff and patients of the institution but to be a resource as a referral centre for the area for the assessment of geriatric, physically and mentally chronically ill, and other appropriate patients, and their recommended placement in a variety of extended care or domiciliary facilities or under a comprehensive home care programme.

34. THAT improved liaison between chronic care units and other appropriate components of the functional spectrum of facilities

for health and social services be promoted by regulation, through governmental consultative services, through voluntary accreditation processes, or by other means.

Nursing Homes

35. THAT long-term governmental policies be formulated, based on such studies in depth as may be required, dealing with domiciliary health care facilities and services in Ontario in respect to such aspects as the following:

    a. the respective responsibilities and roles of public, non-profit, and private agencies in providing and operating "intermediate" care facilities;

    b. the problem of financing "intermediate care" in such a way as to ensure that adequate, high standard nursing and related services are available to all who need them, including study of the feasibility of identifying the health care component of the total costs of care, separating it out from the basic costs of maintenance, and having this health care cost borne through provincial health insurance financing mechanisms (a technique which might be applicable as well to care in other long-term domiciliary care institutions, foster homes, and even the patient's own home).

36. THAT consideration be given to subdivision of licensing of nursing homes, with a particular licence being geared to a particular level of service; and further, that a change of policy be considered whereby homes offering primarily non-health-related service to largely self-sufficient persons would be licensed and supervised but would no longer be designated as nursing homes.

37. THAT the whole process of enforcement of nursing home regulations, licensing, and supervision be greatly strengthened and applied in a more uniform manner by involving the Medical Officers of Health more fully, by instituting special training programmes for nursing home inspectors, and by assuring all concerned of complete government backing as they carry out a difficult and sensitive assignment.

38. THAT the Department of Health lend its full support to various voluntary efforts to upgrade the knowledge, skills, and training

of administrative personnel of nursing homes, as well as issuing regulations requiring stipulated qualifications for administrators by a certain date.

39. THAT, when regional and district health councils are established, their delegated responsibilities include planning for the provision of adequate nursing home facilities and a review and approval function with respect to private proposals for the establishment of nursing homes, and further, that at the provincial level current informal co-ordination efforts be replaced by formal, consistently used co-ordinating mechanisms to assure that nursing home policy matters will receive joint consideration by the Department of Health, the Department of Social and Family Services, and the Ontario Hospital Services Commission. Primary responsibility for co-ordination should be assigned to the Minister of Health.

Homes for the Aged, Rest Homes, and Charitable Institutions

40. THAT, with a view to achieving the most effective and comprehensive health care planning, there be formal, consistently used planning co-ordination mechanisms involving the Department of Health and the Ontario Hospital Services Commission along with the Department of Social and Family Services, (e.g., establishment of a senior level interdepartmental committee required to meet and report regularly to officials at the Deputy Minister level). Similarly, both health and welfare interests should be involved, at district and regional levels, in planning all types of domiciliary care having a health care component, with primary responsibility for co-ordination assigned to a specific Minister.

41. THAT the Province be urged to set a high priority for the programme of Municipal Rest Homes.

Comprehensive Care Programmes

42. THAT there be a reassessment of the current pattern of organization of home care programmes in Ontario, with participation by appropriate consultants, to determine whether the present approach is the most effective possible and in particular to advise on the desirability of incorporating administrative responsibility for comprehensive home care programmes among the recognized responsibilities of local Departments of Health

and of eliminating what appears to be the unnecessary and undesirable split between Home Care (Treatment Services) and Home Care (Services and Supervision).

43. THAT co-ordinated home care programmes organized in accordance with approved patterns be extended throughout Ontario as rapidly as possible and that they be aided in all possible ways to achieve their full potential in meeting needs.

Community Health Care Facilities for Ambulatory Patients

44. THAT the Province recognize the human values and the potential controls over rising health care costs which would result from placing new emphasis on the planned provision of adequate health care facilities for persons living independently in the community outside of institutions, i.e., so-called "ambulatory care facilities."

45. THAT responsible health planning bodies at all levels—notably provincial, regional, and district—accept the concept that a co-ordinated network of health facilities and services can be complete and effective only by encompassing, as an integral part of the network, the facilities and services needed by the vast majority of the population who are not in health care of health related institutions.

46. THAT in developing health resources, the Province give priority to extending financial assistance to public and non-profit agencies for a range of ambulatory care facilities and services designed to promote health, to prevent disease, and to deliver essential health care in the community. These would include:

    a. renovated and revised hospital emergency and out-patient facilities to meet changing needs, planned to facilitate the provision of dignified, responsible care preferably provided through organized professional group action which should generally involve the participation of at least some physicians on a geographic full-time basis;

    b. community health care centres which would provide diagnostic and treatment facilities for groups of physicians, nurses, and other health workers, whose efforts would be directed at the delivery of health care in the community. In certain rural areas, centres of this kind could replace small,

inadequate hospitals or meet needs without the establishment of such hospitals. In urban areas they could supply primary medical care in natural neighbourhoods, including those of low income, those comprising major housing developments, etc. In both types of setting they could be sponsored in various ways, e.g., by municipalities, a health district, a nearby hospital, a co-operative or other non-profit organization, or by a teaching centre for the health professions;

c. community public health centres to provide service and educational facilities for organized community health activities. Official and voluntary health agencies might well collaborate in establishing combined centres. Useful collaboration between public health and clinical personnel in meeting community needs might be achieved by combining a community public health centre with a community health care centre, particularly in rural or problem communities.

Mental Health Facilities

*47. THAT services and facilities for the mentally ill and for the retarded be planned, operated and financed within the context of general health services, and that the role of the Department of Health be redefined now with a view to,

a. integrating the psychiatric treatment services with all other treatment services,

b. integrating those activities designed to promote better mental health and to prevent psychiatric disorders throughout the province with the total effort of this nature in the Department, and

c. integrating the financing of capital and operating costs for adequate psychiatric and mental health services to provide comparable standards of care with other health care programmes. The same principles should apply.

48. THAT psychiatric and mental health services be integrated with the pattern of regional organization being recommended for all health services. The regions should contain the more highly developed psychiatric facilities either located in general hospitals

* Recommendation 47 is the same as Recommendation 2.

or special regional facilities. Included in these special regional services would be facilities for the continuing investigation and care of geriatric cases, adolescent patients, and the investigation and treatment of emotionally disturbed children and the mentally retarded.

49. THAT, to ensure community participation, local boards be established and made responsible for the operation of separate mental health facilities in a way similar to that in effect for public general hospitals.

50. Incorporated in Recommendations 2 and 47.

51. THAT efforts be made to ensure that every general hospital is able to care for psychiatric emergencies, since it has been amply demonstrated that, given adequately trained staff and arrangements for care after the acute episode, the general hospital should be able to admit such patients as it would other emergency cases.

52. THAT a review should be made of the standards, indices, methods and procedures involved in the planning of mental health facilities, including: the standards related to facility location and bed needs, the methods used to identify the need for new types of facilities, the establishing of priorities and the planning process involved.

53. THAT psychiatric and mental health services for children be integrated with and developed in collaboration with psychiatric and general health services for adults and children. (Decision deferred.)*

54. THAT psychiatric units in public general hospitals be fully integrated with appropriate community services and that private practitioners of psychiatry using the facilities of the units be encouraged to provide community consultation services.

55. THAT, while recognizing the important contribution that the Alcoholism and Drug Addiction Research Foundation has to make in public education and research, its operation of facilities

* Council reserved judgment on Recommendation 53 pending receipt, discussion and consideration of a comprehensive background document on the whole issue of separate health care facilities for children.

for treatment at the local level be integrated with the mainstream of health services, education and research.

Health Facilities in Relation to Educational and Research Programmes

56. THAT provision be made in health care facilities of appropriate type for undergraduate, postgraduate and continuing education of health personnel in programmes directed by universities, colleges of applied arts and technology, and regional schools and hospitals.

57. THAT the current trend to bring together educational programmes for several health professions in health sciences centres be encouraged as a means of increasing collaboration among the health professions and evolving more effective methods for the delivery of health care through sharing of responsibility and through operational research.

58. THAT the special clinical resources and higher unit costs associated with health facilities which accommodate clinical training and research programmes be accepted as a recognized cost related to the provision of health manpower and the improvement of the quality of health services.

59. THAT educational programmes for the health professions be organized in relation to the general and special health services and programmes of the district or region in which the educational centre is located, and that those responsible for the education of the health professions be represented on district and regional health councils responsible for area-wide planning and co-ordination of health resources.

60. THAT applied clinical and operational research be developed in balance as an integral function of all major health facilities used for teaching purposes and that research space and equipment be provided to achieve this objective.

61. THAT, in the planning and construction of new or renovated health facilities, the cost assigned for educational programmes be limited to those components specifically used for teaching and research which would normally not be provided in an institution with comparable responsibility for community health services.

62. THAT the substantial long-range benefits in health manpower, regional planning, introduction of new approaches to the delivery of health care, and health research, which may be expected to accrue from the growth of university health sciences programmes be recognized by making sufficient capital funds available now for their early development.

63. THAT if no university health sciences centres are anticipated in the near future in northern Ontario, substitute arrangements for the needs of the area, including the major centres of population, be explored (e.g. independent unit or affiliation with one of the health sciences centres in southern Ontario).

Planning, Design and Construction

64. THAT, for all categories of physical resources for health services, the provincial authorities develop guidelines and objectives for each level of planning. This will include long-range master programmes at provincial level, co-ordination of project and programme planning at regional and district levels, and detailed project planning at the level of the individual health facility.

65. THAT provincial authorities act promptly to expedite the present review and approval process.

66. THAT the Provincial Government create or assist in the establishment of a Health Facilities Design and Information Centre and that the centre have the following characteristics:

    a. be separate from planning and approval agencies and include in its Board of Directors representatives of the several interested disciplines;

    b. provide central facilities and nucleus staff for planning information and advice, a planning library, technical and publication services for investigation and research, space for small conferences and meetings, exhibitions and equipment;

    c. maintain close and cordial relations with government health authorities, with regional organization, with health service, teaching, or research institutions, and with professional associations and research groups interested in planning hospitals and health services;

d. be the originatory or catalyst of new research and investigation related to the evaluation of development projects, new systems and equipment, and new operational methods, with a view to making information more generally available by means of publications, courses, and audio-video media.

67. THAT pre-opening budgets for large or complex health facilities become effective at the appropriate time in the planning of the facility (and certainly before construction begins) and be increased to include a larger number of personnel who will have continuing responsibility for operation of the facility.

SECTION 3
Recommendations by the Committee on Health Manpower
(See reports of June 1968 and June 1969–Annex "C")

Physician Manpower

1. THAT the projected needs for physicians in Ontario should be considered from five main points of view:

   a. recognition that great advantages for the people should be derived from the application of scientific advances in the field of health;

   b. recognition that current demand for health services has outstripped supply;

   c. recognition that a capacity to deliver an improved quality of health care is dependent upon new and more efficient systems of delivering health care;

   d. recognition that future needs for physicians are inseparable from future needs for members of the allied health professions and the health technologies, and health service technicians;

   e. recognition that an increasing proportion of doctors will enter teaching, administration and research and will not practise.

2. THAT Ontario should avoid dependence upon foreign countries and other provinces for 49 per cent of newly registered physicians.

3. THAT Ontario should count on a maximum annual input of 100 doctors per year as immigrants from other countries. (The Economic Analysis Branch of the Department of Treasury and Economics projects a flat rate of 30,000 immigrants, net, per annum, to 1991 in the population projection.)

4. THAT Ontario should not depend upon or take into its calculations doctors from other provinces moving to Ontario to practise.

5. THAT by 1986 Ontario should ensure that there be a net ratio of one practising doctor per 900 people, excluding interns and residents, and an overall gross doctor/population ratio in 1986 of 1:675-680.

6. THAT existing faculties of medicine should be encouraged and provided the means to expand their total admission beyond the presently planned intake by as many students as are compatible with maintaining proper educational standards and availability of clinical facilities, hopefully a total of 20 new as yet unplanned admissions by 1970, reaching 35 by 1978.

7. THAT in respect to new health sciences centres:

   a. a new health sciences centre (in addition to McMaster) should become operational at the earliest possible date, graduating doctors not later than 1978, and capable of as rapid progression as possible to a graduating class of 96 doctors annually by 1983;

   b. continuing consideration should be given to preparations for a second health sciences centre to become operational in the mid-eighties;

   c. provision for dental facilities should be included in health sciences centres. (To be reviewed.)*

8. THAT in respect to the location of a new faculty of medicine, the following conditions should be fulfilled:

   a. it must be part of a multi-faculty university;

   b. it must be situated in an area of sufficiently large and dense population to ensure an adequate number of patients and doctors participating in the medical education programme;

   c. the university must have adequate control of the major teaching hospital to meet its service, educational, and research responsibilities.

9. THAT the Research Committee and the Education Committee

* Council was prepared to accept Recommendation 7 on the basis of the information available (June 1968), but wished to review the recommendation as further information becomes available.

should consider advising the Council of Health to encourage and support, at universities:

a. the study of systems of delivering health services;

b. the study and planning of health education, as it will relate to the new systems of delivering health services, for doctors and members of the allied health professions and technologies.

10. THAT a primary committee be established to study systems of health care delivery, with the Chairman of Council as Chairman, and chairmen of other prime committees as members, and,

THAT the Executive Committee study the matter, to develop it in relation to the Chairmen of Committees and the Executive Committee.

11. THAT community health centres, group practice, and increased utilization of allied health professions and auxiliary personnel, should be supported as research operations in the interest of conservation of medical manpower and improved care of the sick. (Accepted in principle.)*

12. THAT, in respect to doctors' assistants:

a. the preliminary study of the role and need for doctors' assistants by the Research and Planning Branch should be given high priority;

b. the potential role and scope, as doctors' assistants, of the medical assistant, the public health nurse, the registered nurse, the outpost nurse, the midwife, the ophthalmic technician and the surgical assistant technician and undoubtedly others, should be considered with the appropriate groups from health sciences centres and particularly faculties of medicine and of nursing, appropriate Ontario Medical Association divisions, the Ontario Chapter of the College of Family Physicians of Canada, The Ontario Hospital Association, the Ontario Public Health Association, and the Registered Nurses' Association of Ontario.

* Recommendation 11 was accepted in principle and referred to the new committee on systems of health care delivery.

13. THAT physicians should participate:

    a. with economic responsibility in the government and management of hospitals;

    b. with economic incentives and rewards based on a share of the savings resulting from increased effectiveness and efficiency in the utilization of hospitals.*

Dental Manpower

14. THAT the Province expand its resources regarding health to include substantive dental health services within the Department of Health, with the Department having the responsibility placed upon it for the development of resources for the dental health and dental care of the residents of Ontario.

Note: Council discussed Recommendations 15-31 (which follow) and accepted the basic philosophy of these recommendations which are directed to modified methods of delivering dental care and the development of resources for these purposes. Council accepted the need for demonstration projects and urged action in this regard.

Subsequently, a Sub-committee on Dental Care Services was established under the Committee on Health Care Delivery Systems to study all aspects of dental care and develop appropriate demonstration projects. These areas are under active consideration by the Sub-committee.

15. THAT resources to graduate an additional 25 dentists, annually, should be productive by 1973. By 1978, facilities to train a further 125 dentists annually should be developed.

16. THAT by 1972, courses should be established to synchronize, with the development of a school dental health programme, the graduation of as many dental associates as possible, up to 125 per year.

17. THAT therapists (upgraded hygienists) should be trained in a minimum ratio of 2:1 with graduating dentists for ten years, providing for revision of numbers as demand is established for this type of auxiliary.

18. THAT the Province devise some form of financial arrangement to

* Recommendation 13 was referred to the new committee on systems of health care delivery for the careful consideration that it obviously requires.

encourage private practitioners of dentistry to employ dental therapists.

19. THAT conferences be held with the dental professions:

    a. to obtain their co-operation in the training of dental associates for employment only in a school dental health service and under proper and effective supervision by dentists;

    b. to obtain their co-operation in the training of therapists (upgraded hygienists).

20. THAT the Education Committee give consideration to training therapists in the colleges of applied arts and technology distributed throughout Ontario, where suitable clinical facilities can be made available. It would be desirable if first priority could go to those colleges situated close to dental schools, secondly to those colleges close to health sciences centres without a dental school and finally to those colleges close to a university with a department of biology and a nearby hospital with a dental department.

21. THAT the Education Committee give consideration to the feasibility of establishing courses to train dental associates in the colleges of applied arts and technology throughout Ontario.

22. THAT the Education Committee give consideration to the view that more high schools throughout the province should develop formal courses for dental assistants.

23. THAT the Education Committee should be asked to consider and develop a plan supporting the development of competent practitioners as teachers in colleges of applied arts and technology for dental therapists and associates.

24. THAT, in respect to social assistance groups, the possibility of the Province assisting these groups in obtaining dental care be explored further.

25. THAT, in order to lower dental manpower requirements for the care of children:

    a. the Province explore and, if possible, follow the precedents

set by Ireland and certain States in the United States in making water fluoridation mandatory for all municipalities with non-fluoridated central water supplies, as recommended in Minute 49.4 Ontario Council of Health meeting, June 15-16, 1967;

b. dental assistants should be trained to carry out, under proper supervision, topical application of fluorides for school children who live in areas without fluoridated water supplies, as a responsibility of the school dental health service.

26. THAT existing legislation whereby only females may become dental hygienists should be amended.

27. THAT the legal control of hygienists should not be vested in the Royal College of Dental Surgeons of Ontario. ("If some form of regulation is required, then we think that these are clearly cases for provincial licensing boards."—Report No. 1, Volume 3, Royal Commission Inquiry into Civil Rights.)

28. THAT existing legislation restricting the practice of specialists to their specialty should be amended.

29. THAT provision be ensured for on-going operational research and evaluation of the proposed school dental service, and dental service for the social assistance group, with special relation to utilization of dentists and dental associates, and the quality of dental care.

30. THAT faculties of dentistry be given every encouragement, and the financial means, to enlarge the full-time faculty, to expand research resources, to increase the number of graduate students and research scholars who will be the future faculty members.

31. THAT, in respect to a school dental health programme:

a. a programme be developed in Ontario to provide an alternative and optional service to existing resources;

b. this programme be operated under the supervision of dentists, and be staffed by dental associates, employed by the Province of Ontario;

c. the programme start at a time to be co-ordinated with the

body of the report on Dental Manpower;

d. in order to ensure initial staffing, an experimental course for the training of dental associates be started immediately.

Nursing Manpower

32. THAT flexible and attractive working conditions and "career incentive" factors must be introduced on a large scale in order to modify the serious level of attrition. Since the cost of training an average nurse is approximately $11,000, even greater incentives for those already trained would be much less expensive than building and operating the training facilities with which to replace them.

    Additional administrative arrangements of the type which might help to reduce attrition, and for which experimental application is recommended, for example, are as follows:

    a. the organization of day nurseries and elementary teaching facilities either in or adjacent to hospitals, for the young children of married nurses who might thereby be enabled to remain at work;

    b. the inauguration of a province-wide system of clinical certificates or diplomas, giving nurses province-wide status for levels of competence achieved in clinical nursing. The list of certificates available would be established and awarded by provincially recognized post-secondary educational institutions. Appropriate province-wide standards must be established and maintained as well as national standards;

    c. rates of remuneration for nurses should be related to operational responsibility, clinical and/or administrative.*

33. THAT, in calculating future requirements for the training of nursing personnel, Ontario should reduce its dependence on the supply of nurses from other countries and other provinces.

34. THAT a basic rate of immigration should be assumed, based on the principle that immigrant nurses form the same proportion of

* Action on Recommendation 32 was deferred until the opinion of the Committee on the Education of the Health Disciplines could be obtained.

all immigrants as resident nurses form to all residents in Ontario.

35. THAT, as an objective, approximately 20 per cent of nursing personnel should achieve advanced education in one of the following ways:

    a. a basic or post-basic course leading to a university degree—B.Sc.N.;

    b. a post-graduate course leading to a diploma or certificate awarded by a provincially recognized post-secondary educational institution.

36. THAT university schools of nursing remain flexible in their future planning and give equal emphasis to the post-basic degree course and the basic degree course. Post-basic degree students—i.e., diploma nurses who have practised for 3-4 years—should be actively sought out. Special economic incentives should be provided for the education of this career group.*

37. THAT, of total nursing output, approximately 50 per cent should be diploma graduates and approximately 30 per cent should be registered nursing assistants (R.N.A.'s).

38. THAT more efficient utilization of staff along the lines of the team nursing concept, including delegation of non-nursing duties to non-nursing staff, should be encouraged wherever possible.

39. THAT a technique of health care delivery management, utilizing economic incentives for efficient use of hospitals, be introduced on an experimental basis in one or more communities in Ontario. This technique should be carefully studied with a view to reducing in-hospital days of care per 1,000 population and, therefore, the number of nursing staff involved.

40. THAT no increase should be made in present nursing student enrollment estimates for the period ending 1973.

    Revised estimates should now be made for the period after 1973, based upon increased demand for nurses outside general hospitals and decreased demand within such hospitals.

* Action on Recommendation 36 was also deferred until the opinion of the Committee on the Education of the Health Disciplines could be obtained.

SECTION 4
Recommendations by the Committee on The Education of the Health Disciplines
(See reports of June 1968 and June 1969—Annex "D")

1. THAT the following basic principles for the education of the health disciplines be accepted:

   a. programmes for education and training should be conducted within an educational institution and a health service institution;

   b. they should be based on the best and most suitable setting for each course;

   c. they should be based on requirements for teaching, and/or research, and/or service, and/or administration;

   d. they should be broad enough to enable a technician to move on to similar services in other locations;

   e. they should provide some basis for advancement for competent graduates;

   f. students should be educated and/or trained to use their ability to full measure;

   g. techniques must be developed to determine the theoretical and practical knowledge required to carry out the work of each category of auxiliary health workers;

   h. primary attention should be given to those who constitute a "health team."

2. THAT the work of any health occupation be subject to analysis so that its existence or claims for future expansion may be validated.

3. THAT formal requests to government from responsible institutions or parties for:

   a. education and training programmes for new categories of health workers;

   b. major revisions in present educational programmes for particular health occupations;

   c. the setting up in a new location of a programme of education and training for an existing discipline;

include an analysis of the basic skills and knowledge requirements of the occupation in question.

4 THAT, as an aid to evaluation, a document be prepared which, in general terms, lists the different criteria which reflect the interests and requirements of the health community and may be applied to requests to government for:

a. new educational programmes for health occupations;

b. major changes in existing programmes;

c. the setting up in new locations of programmes existing elsewhere.

5. THAT practices which promote interprofessional education among the health disciplines be studied to the end that, if proved to be of benefit to the effective utilization of resources, their growth and/or replication might be encouraged. Such practices to be studied may include:

a. core curriculum design;

b. educational equivalents within or among health occupations;

c. systems analysis.

6. THAT the word "team" (as used in "health team," "nursing team," "rehabilitation care team," etc.) be examined and clarified as to its meaning and use when applied to groups of health care personnel.

7. THAT academic institutions, and other educational institutions for education and training of the health disciplines, be given government support beyond normal operating expenses both for ongoing evaluation of their educational programmes and for the necessary resources required to institute those desirable changes indicated by such evaluation.

Dental Personnel*

THAT, depending on validated estimates of manpower

* Subsequent to Council's acceptance in principle of these recommendations, a Sub-committee on Dental Care was established. All aspects of dental care services are under active study by the Sub-committee. Pilot projects are being developed to test new methods of dental care delivery as recommended by committees of Council.

requirements, planning commence immediately to establish a third dental school in Ontario.

9. THAT a dental consultant be associated with each developing health sciences centre establishing a faculty of dentistry.

10. THAT, where there is a demonstrable need, consideration should be given to establishing courses in dental assisting, at the secondary school level.

11. THAT one-year post grade XII courses in dental assisting should be initiated in colleges of applied arts and technology, where there is a demonstrated need for such courses and where these courses would not jeopardize any other which may be established at the secondary school level.

12. THAT, since one course in dental technician training is already in operation at George Brown College of Applied Arts and Technology, and since there appears to be no need for additional training programmes, no additional programmes for dental technician training be mounted at the present time.

13. THAT the two-year diploma level programme, as is existing or as may be expanded in university dental schools, continue to be available for dental hygienists.

14. THAT colleges of applied arts and technology be encouraged to study the feasibility of mounting diploma courses in dental hygiene in their institutions, such feasibility studies to include the ability of the college to provide and/or arrange for the requisite instruction in basic sciences, adequate and properly supervised clinical experience, and, generally, to meet approved standards for accreditation.

15. THAT there is a need for some dental hygienists to be educated to the degree level for positions in teaching and in senior administration.

16. THAT the legislation and regulations which restrict the practice of dental hygiene to females be repealed.

Nursing Education

17. THAT, at degree and graduate degree level:

a. the Chairman of Council request the College of Nurses to investigate the feasibility of a universal application form with multiple choice of school, to include both the diploma and university schools;

b. the individual university schools of nursing be encouraged to expand their enrolment at an early date and actively to seek solutions to overcome the deterrents to such expansion;

c. university schools of nursing establish priorities in their own communities for the use of clinical facilities that would be required by them;

d. the individual university schools of nursing be requested to explore ways and means to identify and recruit graduates of diploma schools of nursing into the post-basic baccalaureate programmes, and to find ways of offering baccalaureate nursing education to the registered nurse on other than a full-time basis, such as summer sessions, evening classes and programmes in satellite communities;

e. a second graduate degree programme in the specialty areas of nursing be established in Ontario as soon as possible;

f. ways and means be found to offer education to the baccalaureate prepared nurse in preparation for leadership roles in nursing education and specialty areas, such courses to count as credit toward a graduate degree;

g. financing for capital expenditures and operating costs of existing university schools of nursing be reviewed by the Provincial Government and senior university officers;

h. until a review of the problems of expanding the present university schools of nursing has been carried out, no new university schools of nursing be established.

18. THAT, at diploma level:

a. some diploma programmes in nursing should eventually be established within colleges of applied arts and technology, with the approval of the appropriate agencies.

It is agreed that there be three phases to the development of such programmes:

(1) a co-operative programme, where colleges provide special academic services to the hospital school or the regional school of nursing;

(2) an integrated programme: in this phase, liaison between the hospital and the college would be much closer.

(3) an autonomous programme:

(a) in this phase, the college would assume full responsibility for all aspects of nursing education after passing through phases (1) and (2);

(b) where no regional school of nursing has been established, phases (1) and (2) may be omitted.

b. the plans for the establishment of regional schools of nursing be extended as quickly as possible to meet the geographic needs of the Province, in addition to, but where appropriate co-ordinated with, the development of the college of applied arts and technology programme.

Nursing Education and Supporting Resources

19. THAT the Department of Health find ways and means whereby interdepartmental communications could be developed, in order to facilitate co-ordinated planning for the development of educational programmes for nurses and auxiliary nursing personnel and to ensure the availability and effective utilization of required clinical facilities for the various programmes.

Education and Training of Nurses for Public Health Services

20. THAT in respect to the preparation of Public Health Nurses:

a. the Ontario Council of Health recommend, contingent upon the agreement of the institutions concerned, the establishment in Ryerson Polytechnical Institute, on an experimental basis for five years, a certificate course in public health nursing, and it is suggested further that an advisory committee be set up with membership from Ryerson Polytechnical Institute, public health nursing fields, and the University of Toronto, to study the curriculum and other matters associated with the programme;

b. universities which are offering certificate courses in public health nursing be encouraged to continue in this field at least while this matter is under study;

c. a study be conducted in at least two official agencies, one urban and one urban-rural, to determine the composition of

the team, the functions and responsibilities of each category of nursing personnel and their relationships to each other, and financial aid be made available for each study.

Orthoptic Ophthalmic Technicians

21. THAT the present general arrangements for, and location of, education and training of orthoptic ophthalmic technicians in the new school of orthoptics at the Hospital for Sick Children be approved, and that, in so recommending, Council does not in any way wish to prejudice any statements it may make in the future about this discipline.

Evaluation of the Usefulness of Existing Health Service Occupations

22. THAT the Council of Health consider as an urgent matter the need to obtain for use by the Committee substantial information concerning:

    a. the appropriateness of the care which health workers are providing for the people of Ontario;

    b. the efficiency of health workers of Ontario in carrying out the tasks which they are undertaking.

23. THAT the Council of Health, in order to obtain the information which is needed by the Committee, proceed as soon as possible to identify, commission and support adequately experienced and proven individuals and/or organizations to:

    a. identify manageable problems in the areas of uncertainty alluded to in the preamble to this recommendation;

    b. draw up investigative projects bearing upon the resolution of the problems so identified;

    c. work through and bring to completion the investigative projects which, in the judgement of the Council, seem likely to provide the Committee with information bearing directly on the Committee's capacity to function effectively in respect to its terms of reference.

SECTION 5
Recommendations by the Committee on Library Services
(See report of June 1969–Annex "E")

The Health Sciences Information Network

1. THAT, to keep pace with rapid advances in medical and allied health subjects and to provide optimum library arrangements for the health services, a health sciences information network, initially based on existing facilities, be developed in Ontario, and that the network comprise three levels of responsibility:

   Level 1 – primary contact library
   Level 2 – health resource library
   Level 3 – central resource

2. THAT the Department of Health enter into negotiations with the appropriate agencies of the Federal Government to enable use of federal level resources as the central resource for the provincial health sciences information network.

3. THAT the information resources of health sciences centres in Ontario be part of the information network, and the five health sciences centre libraries be requested, and funded, to assume regional network responsibility as health resource libraries.

4. THAT health personnel be informed of their primary contact library and the three levels of service of the health sciences information network for their region, and that users be encouraged to enter the network via their primary contact library.

The Role of the Ontario Department of Health

5. THAT at least one qualified medical librarian (with appropriate support staff) located within the Department of Health be designated provincial co-ordinator and advisor for the health sciences information network.

   His responsibilities will include:

   a. to assist and maintain liaison with federal level library services;

   b. to encourage private provincial associations which have

significant library resources to participate within the provincial network;

c. to provide assistance and consultation services to network libraries.

6. THAT an operating committee be established, including the chief librarians of the health resource libraries and other appropriate persons, to work with the provincial co-ordinator who will be appointed chairman of the committee.

7. THAT a health sciences librarian, located in the health resource library for the region, be designated regional co-ordinator.

8. THAT, included in a network programme for information service, there be a field staff of librarians, available within each region, to provide professional consultation and advice to health sciences information facilities, whether or not such facilities form part of the designated information network.

Network Co-ordination and Mechanism

9. THAT health sciences librarians maintain close administrative arrangements and personal liaison with librarians of parent institutions, related libraries in other disciplines, and library organizations in the province and nation.

10. THAT, before a sophisticated system for interrogating files of computerized data is considered for Ontario, a relatively simple system and network be implemented. Successive objectives of the system would include:

a. compatibility of bibliographic records in all health sciences centre libraries;

b. a catalogue in machine readable form;

c. inexpensive book catalogues provided from the mechanized data base;

d. each health resource library to hold book catalogues produced in other regions.

11. THAT every primary contact library subscribe to Index Medicus,

both the monthly issues and the annual cumulation.

12. THAT all health resource libraries, and at least one health library in each centre having a group of hospitals or health services, have Telex.

13. THAT a controlled experiment be initiated with Inward WATS telephone information service when offered in Ontario.

14. THAT extension of an interlibrary courier service to major centres of health services be explored.

Health Library Manpower

15. THAT the Committee on Health Manpower direct its attention to the problem of adequate supply of health sciences information manpower, at both professional and technical levels, with indications of avenues of training and probable need as set out in this report.

16. THAT a health sciences librarian be included on the advisory committee for library technician courses at the colleges of applied arts and technology, wherever it seems likely that diplomates from these courses may find employment in health sciences libraries. Such advisory committees are already recommended in general terms to include a representative from the field of special librarianship.

17. THAT the development of a health sciences information network make adequate provision for a continuing programme of training for health sciences information technicians, both by the provision of short courses for staff now active in such units, and by the provision of training for health sciences technicians interested in transferring to the information field.

18. THAT courses for library technicians make available specific technical subjects for health sciences information technicians—for example, familiarity with reference tools in the health sciences.

19. THAT programmes of scholarship and assistance be continued and expanded to attract candidates with a bioscience or premedical background into training for health sciences information services.

20. THAT training programmes and courses, made available by or on behalf of the health sciences information network, include the necessary assistance for all concerned persons to participate.

21. THAT library schools devote increased attention to the needs of persons already working in health sciences libraries and information services. This might include some courses for degree programmes during the summer months for persons unable to devote extended periods to full-time studies.

Assessment and Evaluation

22. THAT the Committee on Library Services examine the network during its implementation phase, and that the Ontario Council of Health continue to advise the Minister of Health on matters relating to the health sciences information network.

23. THAT appropriate pilot projects important to the development of the proposed health information network be formulated by the Committee and supported by the Department of Health.

SECTION 6
Recommendations by the Committee on Health Research
(See report of October 1969—Annex "F")

General Policy

1. THAT the following definition be considered as the provincial role in health research: "The provision of the facilities and resources necessary, in addition to those from federal and other sources, to achieve an integrated operation in respect to the pursuit of fundamental knowledge, and the application of this knowledge in the improvement of health, in the management of disease in the community, and in the assessment of the efficacy of health care."

2. THAT, as a basis for determining funds for health research, allocations be considered in relation to the needs of health care programmes.

3. THAT, subject to Recommendation 1, provincial support ensure that the universities, communities, and government groups, have sufficient resources to provide a smooth interplay among the activities of education, research, and service.

4. THAT the Ontario Council of Health act as an advisory body through its committees to make appropriate recommendations in respect to the implementation of Recommendations 1, 2 and 3 above.

5. THAT the allocation of all funds for health research by the Province be made on the recommendation of a representative review committee which has had the opportunity of appraising such arrangements for funds in the light of provincial needs, such a representative committee to report to the Ontario Council of Health, and Council in turn to advise the Minister on this matter.

Financing of Health Research

6. THAT, in the allocation of capital funds available from the Province for financing of health research, Recommendation 5 is applicable.

7. THAT a mechanism be evolved for establishing continuing collaboration among the Department of University Affairs, the Ontario Hospital Services Commission, and the Department of Health, for the provision of operating funds for health sciences centres.

8. THAT additional support, related to the aggregate salaries of the full-time staff engaged in health research, be made available from provincial funds for the sole purpose of sustaining the continuing basic cost of research activities of a discipline and related fields.

9. THAT all personnel (professional, technical and support) engaged upon health research, which is integrated closely with teaching or patient care, be financed through provincial funds identified with the institution.

10. THAT the Province maintain a flexible research support programme which complements existing programmes.

11. THAT, in order to maintain an effective professional staff in health sciences centres, an additional funding mechanism be developed to support a research activity which is essential for the education and service activities of the institution.

12. THAT applications for funds for basic multi-purpose equipment or for the more specialized project-oriented equipment be received and awards made as required, and be considered as a whole.

13. THAT proposals for contract health research initiated by agencies of the Provincial Government be reviewed by the Health Research Committee of the Ontario Council of Health, and recommendations made in respect to the scientific merit of the proposal and the method of study.

Special Groups of Outstanding Merit

14. THAT the needs, in respect to resources and personnel for special groups in health research, warrant the reiteration that Recommendation 5 covers the provincial need in this area.

Voluntary Health Agencies

15. THAT, because of the important and unique role played by the

voluntary agencies, these agencies should be actively encouraged to continue to expand their activities. It is further recommended that, when a particular activity of the agency becomes part of the health care programme, the funding for this activity be provided on a continuing basis.

Existing Provincial Support for Health Research

16. THAT the provincial role in health research continue to remain flexible and responsive to changing needs.

17. THAT all funds for health research provided by the Department of Health or other departments be identified as such in the annual estimates of the department concerned.

18. THAT foundations, such as the Alcoholism and Drug Addiction Research Foundation, the Ontario Cancer Treatment and Research Foundation, and the Ontario Mental Health Foundation, continue to be eligible to receive provincial grants for the support of the research component of their operation and, further, that the budgetary requests from these foundations be submitted annually along with an estimate of the requirements for the ensuing five years.

19. THAT, in view of the success of the above programmes and the rapidly emerging needs in health research, a machinery be developed to respond quickly to new needs as they become apparent.

20. THAT the three foundations, referred to in Recommendation 18 above, be encouraged to use peer group assessment and external referees in making allocations of research funds for both extramural and intramural research programmes.

21. THAT the allocation of all funds for health research by the Province be made on the recommendation of a representative review committee which has had the opportunity of appraising such arrangements for funds in the light of provincial needs, such a representative committee to report to the Ontario Council of Health, and Council in turn to advise the Minister on this matter (Recommendation 5). (In this way allocations to the three foundations referred to above would be considered at the same time and in the same context as other new research programmes such as the provincial research grant programme initiated in 1968.)

Developmental and Applied Research

22. THAT consideration be given to providing administrative arrangements and provincial resources in support of applied and developmental research associated with health care in this province.

23. THAT, in effecting this proposal, there be careful co-ordination with other agencies now supporting programmes in health research.

24. THAT, in order to improve the quality and extent of applied and developmental research, new training programmes and special funding mechanisms be applied to this area when required.

The Interdisciplinary Nature of Health Research

25. THAT, since resources are limited and it is important to maintain high standards in all areas of health research activity, encouragement be given to the development of comprehensive graduate school programmes in the health sciences.

26. THAT, to achieve the objectives of Recommendation 25, mechanism be developed to encourage and support interdisciplinary research and graduate study programmes among all the health disciplines.

27. THAT encouragement be given for multidisciplinary research programmes and graduate programmes involving university and community groups.

The Training of Research Personnel

28. THAT support be provided to encourage the training of suitable individuals in health research; the programmes be such as to identify students with talent and facilitate and encourage their development; and the training programmes be of a uniformly high standard.

29. THAT university graduate schools be sufficiently broad and flexible so that effective graduate programmes on an interdisciplinary basis in health sciences be encouraged.

30. THAT the training requirements of professional organizations

and universities be such as to encourage rather than discourage the scientific training of personnel in the clinical areas.

31. THAT special funding be provided to help initiate and develop combined professional and Ph.D. programmes.

32. THAT special programmes be established to enable existing members of staff to undergo any special retraining, related to research activities, which is considered necessary by both the individual and the health sciences centre.

Health Research in Dentistry, Pharmacy, and Nursing

33. THAT research in dentistry, pharmacy, and nursing, be part of an interdisciplinary research programme in the health sciences.

34. THAT, in keeping with the recommendations on the interdisciplinary nature of health research, graduate research programmes in dentistry, pharmacy, and nursing, be oriented in terms of the research objectives, rather than a sectional interest of the professional personnel involved.

35. THAT, when necessary, special fellowship programmes be established to encourage the training of individuals in health research in the disciplines of dentistry, pharmacy, and nursing.

36. THAT special programmes be instituted for retraining purposes. The special programmes related to retraining are particularly applicable to dentistry, pharmacy, and nursing. (See Recommendation 32.)

37. THAT, because of the importance of prevention in dental care and the need for research in this area, substantial funds be made available for the development of health research in dentistry.

38. THAT, when appropriate, teaching hospitals and group medical programmes at health sciences centres develop comprehensive dental departments to provide dental clinical research opportunities.

39. THAT, in respect to nursing, centres be developed in Ontario for the training of nurses in research, as distinct from professional, job-oriented master's programmes.

Research by Disciplines Allied to the Health Sciences

40. THAT since many major advances in the health sciences have had their origin in basic biological discoveries, research in biology, social science and agriculture should be eligible for support by health agencies. Departments of universities engaged in social science, agricultural or biological research should be eligible for research grants from the Department of Health when the project is considered relevant to health research, within the terms of reference of the provincial role in health research.

41. THAT recognition be given to the importance of a comprehensive research programme on pollution, with priorities, and including a health research component. Universities should be encouraged to develop programmes of research into health problems related to pollution. Encouragement should be given to the expansion of Department of Health investigations into pollution.

42. THAT, in order to have a satisfactory overview on pollution and to develop sound policies for reducing their hazardous effects, we urge the appointment of an environmental quality committee of the Ontario Council of Health, made up of informed and interested persons, charged to provide advice to Government on all matters related to pollution.

Role of Federal Agencies

43. THAT, taking into consideration Recommendations 44 and 45, the Province affirm the concept of allocation of federal resources for health research on the basis of national interest, and the general scheme of funding by federal agencies.

44. THAT, because of regional needs and specific community goals, and because of the continuing role of the Province in the interrelated areas of teaching, service, and research, the Province maintain a strong health research capability.

45. THAT, because of Recommendations 43 and 44 above, the mechanisms of co-ordination between provincial and federal authorities be strengthened by appropriate provincial representatives on national bodies, and/or by the constitution of special committees for this purpose.

Health Care Research

46. THAT highest priority in the funding of health care research should go to:

    a. research in end-results among patients who have received health care in experimental situations;

    b. research in cost-effectiveness should be carried out using models, the validity of which has been established by end-results analyses.

47. THAT, while individuals' and health professionals' perceptions of need and actions are important indicators of health research priorities, "process" research should only be encouraged in areas where the effectiveness of the service programme under study in maintaining or improving health has been demonstrated.

48. THAT, since personnel skilled in the methods of epidemiology, biometrics, economics, and operations research, are required for end-results and cost-effectiveness research, high priority must be given by universities to the training of investigators in these methods.

49. THAT careful consideration should be given to the creation of a health services research capability, both in association with health sciences centres in Ontario universities and within government, which would combine the disciplines of epidemiology, biometrics, health economics, and operations research. There should be a capability to perform both independent and contract research, provide consultation services, and train additional health care research workers in these disciplines in these skills.

50. THAT, since biomedical research is inseparable from health care research, careful consideration should be given to the development of methods which facilitate information transfer between all areas of health research. Special support should be available for integrated programmes of health research which include both biomedical and health care components.

51. THAT, since universities and the Province share responsibility for assessing and developing university programmes in education and research relative to provincial health problems, universities, communities, and governmental departments, and particularly

groups within these structures, should participate in an open exchange of policy views, information, and manpower.

52. THAT programmes to be supported by the Province, related to health educational and research facilities and experiments or demonstrations in health care programmes, should be assessed by competent groups prior to their initiation.

53. THAT innovations arising from health services and biomedical research should continuously influence health education. Therefore, health professional education must continue throughout the career of the learner, and must be responsive to both these innovations and to the total health services system. Support should be provided for realistic educational programmes in areas relevant to continuous education of health professionals, commencing at the beginning of health professional education.

SECTION 7
Recommendations by the Committee on Health Statistics
(See report of January 1969—Annex "G")

1. THAT the health statistics system be capable of providing comprehensive statistical services based on data of adequate quality, and that the essential co-ordination, standardization, and evaluation of the system be the primary responsibility of an appropriate unit of the Department* of Health itself.

2. THAT the Department have access to copies of tapes from the Census Division of the Dominion Bureau of Statistics bearing Ontario population data at decennial and quinquennial census years and, further, that arrangements be made for computer processing of these data to provide the demographic information needed for provincial or local studies of health problems and health care.

3. THAT the Department make formal arrangements for the inclusion of its appointee as a full member of any provincial task force charged with advising the Dominion Bureau of Statistics on the preparation of census schedules, and that the Department take the initiative in formally advising the Dominion Bureau of Statistics at an appropriate early time of its requirements with respect to the census.

4. THAT, in order to facilitate the estimation of local demographic data for intercensal years, the Department have access to population data obtained from the annual municipal household assessments, at least in tape form.

5. THAT the Department seek the co-operation of the Department of Municipal Affairs in ensuring that relevant changes in local census methods, schedules, and codes, serve to increase the usefulness of data for health purposes.

6. THAT, for purposes of planning, the Department, in the interests

* Except when qualified, as in the present instance, the term "Department" means all health related provincial agencies reporting to the Minister of Health, including the Ontario Hospital Services Commission and the Health Insurance Registration Board.

of uniformity and efficiency, continue to make use of those population projections already available from the Economic Planning Branch, Department of Treasury and Economics.

7. THAT in the next major review of the content of the existing record forms for marriages, births, deaths, adoptions, and divorces in Ontario, special attention be given to the value of social and biological data such as occupation and racial origin, and of specific identifying information such as the birth dates of parental couples by means of which these records may be linked together into family groups, for studies of family formation and dissolution, and familial patterns of disease occurrence.

8. THAT the reporting of foetal deaths by physicians be extended to include all foetal deaths, regardless of the period of gestation.

9. THAT the reporting system for communicable diseases be re-examined with a view to facilitating the early and complete reporting of serious and controllable infectious diseases and the development of reporting on an adequate sampling basis for infectious diseases whose remote consequences are unknown.

10. THAT insured individuals in Ontario Medical Services Insurance Division and Ontario Hospital Services Commission, or other persons served by these organizations, be identified by a number (or numbers) common to all systems, that will identify the individual and his corresponding family group. Such a numbering system could be based on the Social Insurance Number in addition to any separate Ontario Medical Services Insurance Division or Ontario Hospital Services Commission number that may be required for administrative purposes.

11. THAT the Health Insurance Registration Board collect data on hospitalizations under Ontario Hospital Services Commission and on physicians' services under Ontario Medical Services Insurance Division in such a way that annual incidence rates of various diseases, disorders, and injuries, within the insured population, can be calculated. The preferred method for accomplishing this would be to require an indication on claims for payment by hospitals and physicians of those diagnoses which were first established in the course of the medical care involved in the claim.

12. THAT individual patient data arising from hospital or medical

claims processed by Ontario Hospital Services Commission and Ontario Medical Services Insurance Division, respectively, be retained for the purpose of retrospective studies, especially those for disease entities of low frequency. Original claim forms should be retained where feasible. More importantly, the magnetic tape record as coded from the original individual document should be permanently retained. If it is necessary to remove an individual record from the "active file" tape, it should be transferred to a "dead file" tape for permanent storage. This recommendation proposes the continuance of current Ontario Medical Services Insurance Division practice and an initiation of the same practice by Ontario Hospital Services Commission.

13. THAT, in respect of accident data, at least for the principal injury the external cause of injury be recorded on hospital and physician claim forms, in order to delineate components which contribute most to the total accident rate and those whose occurrence could most readily be reduced by preventive programmes.

14. THAT statistics be collected annually from institutions which provide a relatively permanent residence for persons who are physically or mentally disabled or are particularly likely to be so. These institutions would include nursing homes, homes for the aged, homes for the blind, mental hospitals, chronic disease hospitals, homes for the disabled, and similar institutions. The statistics collected would indicate the number of admissions, duration of disability, discharges to private residence, transfers to other institutions, death during the year of persons with physical and mental disabilities, and the number of such persons resident in the institution on a particular date, all classified according to age, sex, nature of and functional extent of disability or impairment. They would include only those individuals whose residence was considered to have been the institution while they were staying there.

15. THAT a continuing health survey be conducted in a suitably designed representative sample of the population of the province; a minimum size of about 2,000 households per year is suggested. This might be carried out in co-operation with other departments of the Ontario Government or the Dominion Bureau of Statistics. From such a sample, special information could be obtained, varying in its content from time to time according to the requirements of the Department or other health agencies, on the

incidence and prevalence of diseases and disabilities, on the use of health care facilities, on unmet needs for medical care, on attitudes to, knowledge about, and practices relating to health matters, and on physical and other characteristics whose relationship to health needs to be defined.

16. THAT, in the coding of the cause of death from the Medical Certificate of Death, all causes listed in section 6 of the certificate be coded to make this information accessible for special studies. This might also afford an opportunity to automate the selection of the underlying causes from those listed in section 6 of the certificate.

17. THAT, it being desirable to have mortality data supported by an autopsy report, when one has been performed, to this end a uniform pathologist's autopsy report be developed for Ontario with a view to its completion on a routine basis by pathologists and its incorporation into the mortality reporting system.

18. THAT a mechanism be developed for reporting preventive and diagnostic screening procedures, such as immunizations and Papanicolaou smears. The reports could serve a number of purposes:

    a. to provide data on the frequency of such procedures, in different segments of the population;

    b. to facilitate studies of the effectiveness of preventive measures and of the value of diagnostic screening procedures;

    c. to permit access to individual data of such kinds, where needed for the purposes of health care.

19. THAT a register of physical resources be established for Ontario to include information on capacities, type and volume of services, type and numbers of health personnel, location, and population served, with respect to:

    a. general, special, and psychiatric hospitals and tuberculosis sanatoria;

    b. nursing homes;

    c. ambulatory and out-patient treatment facilities;

d. public health units and departments;

e. voluntary health and related agencies serving people in Ontario.

These registers should be maintained by a system of annual reports or returns. The annual returns of hospitals and temporarily approved nursing homes will serve this purpose for the institutions which they cover.

20. THAT the Department ensure that adequate information on health personnel is available for health planning purposes for at least the following categories: doctors, dentists, and nurses. For each of these categories, the data should be recorded in register form and should include:

a. location;

b. age;

c. sex;

d. employment status, e.g. full-time, part-time, retired;

e. nature of major work or employment, e.g. private practice, hospital, public health.

21. THAT, for health service operational data:

a. the health statistics system include adequate provision for data on the availability, use, and cost of health services, to serve the purposes of planning, operation, and evaluation;

b. although additional information concerning operations need not be centralized because it is primarily a responsibility of the operating institution and financing institution, such additional information should be accessible to the Department;

c. the regular statistics required for administrative operations be supplemented on a special study basis as required for planning and evaluation in relation to standards or other criteria of health care.

22. THAT the health statistics system for Ontario develop and incorporate all relevant data for the monitoring and evaluation of the health effects of environmental factors and for the development of standards of exposure to environmental pollutants.

    This would require, for example, that data concerning the quality of water, air, and food, be collected, stored, and processed in such a way that they can be related to geographically relevant morbidity and mortality data.

23. THAT the health statistics system for Ontario incorporate data from industrial health records to assess the extent of exposure to risk from contaminants or other hazards and also to evaluate existing threshold-limit criteria or to establish new ones.

24. THAT the Department stimulate, assist in, or conduct epidemiological and other field studies of the health of occupational groups and of the health effects of specific occupational exposures.

25. THAT, since many of the foregoing recommendations require for their implementation the bringing together of a variety of health data pertaining to one individual or family, the health statistics system ultimately acquire the capacity for complete data linkage, together with the technical and legal means to ensure that individual privacy is adequately protected. As a currently feasible first step, the following types of record linkage are suggested:

    a. linkage between hospitals records, to identify repeat admissions of the same persons;

    b. linkage between hospital and death records, to provide information on the outcome of treatments that patients have received in hospital;

    c. linkage between medical care insurance claims for the same individual;

    d. linkage between medical care insurance and hospital records (see Recommendation 10);

    e. linkages within the vital records system to establish family relationships, for studies of family constellations of disease.

Permissible specific applications of record linkage are limited by the quality of the original records in relation to the new purpose and must recognize the limitations implicit in coding.

26. THAT the Department initiate discussions with other departments of the Ontario Government and with the Federal Government concerning the feasibility of giving to a single national governmental office the responsibility for issuing unique individual numbers to every member of the population regardless of age or employment status.

SECTION 8
Recommendations by the Committee on Health Care Delivery Systems
(See reports—Annex "H")

This section is comprised of recommendations by the Sub-committees of the Committee on Health Care Delivery Systems.

SUB-SECTION A
Recommendations by the Sub-committee on Highly Specialized Services
(See report of October 1969—Annex "H")

Open Heart Surgical Units

1. THAT, when consideration is given to approving the establishment of new open heart surgical units and to the closing of existing units, study be made of such factors as pupulation served, number of operations performed, and impact on other cardio-vascular services, and that this include educational implications.

Renal Transplantation Units

2. THAT renal transplantation units be established only in university medical teaching centres, and that their establishment or continued operation be subject to the availability of adequately trained staff.

3. THAT the staffing of each renal transplantation unit should consist of a trained team including a urological surgeon and a nephrologist competent in the administration of immuno-suppressive therapy.

4. THAT each renal transplantation unit be established in close

association with a renal dialysis unit.

5. THAT haemodialysis units be established only in university medical teaching centres and in other regional or major district centres where this is warranted because of population density or distance factors (e.g. Windsor, Sudbury, Thunder Bay) and where adequately trained personnel is available.

6. THAT haemodialysis units consider the provision, under their direction, of satellite dialysis units in appropriate district hospitals, and of home dialysis programmes.

7. THAT minimal staffing of each dialysis unit include at least two technicians, two nurses, and two physicians who are adequately trained in the management of dialysis equipment, along with suitable surgical personnel.

Neurological and Neurosurgical Units

8. THAT neurological and neurosurgical units be established only where these two specialties are present and integrated functionally.

9. THAT the following specialized supporting services be provided as a minimum in association with each neurological-neurosurgical unit: neuroradiology, electro-encephalography, echo-encephalography, and brain scanning.

10. THAT the following highly specialized supporting services (which need not be provided in each institution) be available in special centres which are capable of meeting the total needs of all units: diagnostic clinical neurophysiology, neuropathology, and neurochemistry.

11. THAT the following highly specialized supporting services be made available in teaching hospitals of medical schools, but not necessarily in all such hospitals, and also to some extent in specialized institutions such as the Ontario School for the Deaf: advanced and objective audiometry, specialized vestibular studies, speech therapy, and therapeutic ultrasonics.

12. THAT centres for specialized otolaryngological pathology in the province be situated only in a properly staffed teaching hospital laboratory of a medical faculty.

Ophthalmology

13. THAT the following highly specialized supporting services be represented in some (not all) teaching hospitals of Ontario faculties of medicine and in selected non-university regional centres: orthoptics, and glaucoma laboratory and associated visual field analysis.

14. THAT the following highly specialized supporting services be represented in some (not all) teaching hospitals of Ontario faculties of medicine: retinal photography, including angiography, retinal photocoagulation, and contact lens clinic.

15. THAT the following highly specialized supporting services be situated in one teaching hospital or laboratory of Ontario faculties of medicine, if adequate local interest or resources are present: ophthalmic pathology, diagnostic microbiology, electroretinography, electro-oculography, ultrasonography, and low vision aid clinic.

16. THAT the following highly specialized supporting services be situated in one teaching hospital or laboratory of an Ontario faculty of medicine: eye bank laboratory, electromyography, radioisotope studies, medical genetics (ophthalmic) and karyotyping, dark adaptometry, specialized colour vision testing, and aniseikonia testing.

Paraplegic Units

17. THAT, in order to attract staff of requisite training and calibre, paraplegic units be 20 beds or more in size.

18. THAT paraplegic units be sited only within regional centres, and only where warranted by area population.

Burns Units

19. THAT, depending on area need, one or more burns units be developed in each regional centre of the province.

Hyperbaric Units

20. THAT no additional hyperbaric units be established at this time.

Rheumatic Disease Units

21. THAT a unit consist of 20 to 40 beds in a teaching hospital, segregated for the care of arthritic patients, with associated research and teaching space, directed by a competent staff of rheumatologists and other specialists.

22. THAT rheumatic disease units be developed in each of the medical schools, and in major district centres where warranted by area need and where suitably trained staff is available.

23. THAT one provincial medical school establish a paediatric rheumatic unit in a children's hospital on an experimental basis to evaluate its achievement.

Clinical Investigation Units

24. THAT clinical investigation units be established in university or major affiliated hospitals in medical teaching centres, but not necessarily in all such hospitals.

25. THAT, in selected other regional and major district centres, an area of a hospital ward be designated as a diagnostic study area, where special diagnostic procedures can be carried out.

26. THAT clinical investigation units be established only where there are available:

    a. properly trained staff including specially trained nurses, a physician trained in clinical investigation;

    b. adequate supporting facilities including 10 to 12 beds as a separate entity or as part of a metabolic ward, a special diet kitchen, an aliquot room, a procedures room, and a special laboratory.

Gastro-intestinal Units

27. THAT a gastro-intestinal unit be established only where, in addition to the usual diagnostic facilities of a major district hospital, there is access to special supporting laboratory, radiological, nuclear medical and surgical services necessary for the advanced diagnosis and treatment of gastro-intestinal disease.

28. THAT gastro-intestinal units be established in university teaching hospitals and in other appropriate hospitals in regional centres.

Radiotherapy Units

29. THAT encouragement be given to the appropriate authorities for the development of a radiotherapy unit in north-eastern Ontario.

30. THAT units which provide only radiotherapeutic services be encouraged also to provide chemo-therapeutic services under a physician with special interest and training in this field.

Radioactive Isotope Units

31. THAT the establishment of a radioactive isotope unit, the type of unit, and the type and amount of equipment provided in a unit, be related to area needed, and that small units in district centres be approved for diagnostic purposes only.

32. THAT the facilities necessary for a diagnostic and therapeutic unit be considered to include an organ scanning area, a laboratory, a radio-iodine uptake area, a blood-letting space, a counting facility, a radio pharmacy, and a radioisotope administration area.

33. THAT there be only two whole-body counting units, which require enclosure in a shielded room, in the province.

Intensive Care Units

34. THAT intensive care units be established in appropriately sized hospitals, using the criterion of 3.5 per cent of medical-surgical beds, and that no intensive care unit be of less than four beds.

35. THAT, in instances where the percentage formula does not justify the minimum number of four beds, consideration be given to the designation of a multi-purpose room for constant care, including monitoring, to be situated near the nursing station.

36. THAT separate special purpose intensive care units (coronary care, respiratory failure, and perinatal) be established only if the population served makes each unit viable as a separate entity, and only where trained staff is available.

Coronary Care Units

37. THAT, where a separate coronary care unit is not considered necessary, intensive coronary care be part of the function of a hospital's intensive care unit or of a multi-purpose room for constant care.

38. THAT criteria for establishment of a coronary care unit be: a case load of myocardial infarction sufficient to produce a bed occupancy of 70 to 85 per cent throughout the year, in a unit of not less than three and not more than eight beds for an average length of stay of five days.

39. THAT in both intensive care units and coronary care units there be adequate equipment and trained staff to provide:

    a. monitoring surveillance of cases of myocardial infarction;

    b. prompt treatment of cardiac arrest.

Respiratory Failure Units

40. THAT each regional centre in the province be encouraged to develop one or more respiratory failure units, depending on area need and the other qualifications listed in Recommendation 36.

41. THAT each non-teaching hospital of over 400 beds be encouraged, with the help of the Ontario Hospital Services Commission, to attract to its staff a general physician with an understanding of respiratory function who is capable of performing elementary tests of pulmonary function.

Pulmonary Function Laboratories

42. THAT each major respiratory failure unit have a supporting pulmonary function service laboratory.

43. THAT pulmonary function service laboratories be an integral part of every teaching hospital.

44. THAT encouragement be given to the development of pulmonary function service laboratories in district hospitals where no respiratory failure unit exists.

45. THAT pulmonary function research laboratories be limited, in general, to university centres, preferably in large teaching hospitals.

Genetic Counselling, Chromosomal Analysis, and Metabolic Screening

46. THAT undergraduate, postgraduate and continuing education of physicians contain instruction in genetic counselling to enable primary delivery in out-patient departments and doctor's offices.

47. THAT pathologists of all district and regional hospitals function at a secondary level for routine karyotypes and limited metabolic screening.

48. THAT university-based laboratories be available for the advanced interpretation entailed in certain types of counselling.

49. THAT a provincial committee be established and maintained to survey available resources in genetic counselling, to determine immediate tasks in that field, and to develop long-range plans for the establishment and function of a province-wide organization to provide assistance with problems of detection, management, and prevention of genetically determined disease.

Perinatal Units

50. THAT regional perinatal (obstetric/paediatric) units be set up at strategic locations throughout the province, usually, but not necessarily, in medical teaching centres.

51. THAT the existing Provincial Perinatal Mortality Study Committee be expanded; that its title, membership, and terms of reference, be reviewed in the light of current needs of the Department of Health for advice on matters beyond the study of perinatal deaths, and that a primary function of this committee be the surveillance of perinatal mortality and perinatal morbidity.

52. THAT the Medicial Officer of Health of each Health Unit have available on his medical staff a physician, preferably with paediatric training, who is capable of supplying medical examinations and information regarding learning disabilities to the County School Boards.

Cerebral Palsy

53. THAT the Department of Health encourage physicians and medical groups in outlying areas to invite the Ontario Society for Crippled Children, or other appropriate agency, to provide clinics for the detection and initial therapy of handicapping conditions such as cerebral palsy, on a regular basis.

54. THAT treatment services be expanded to allow several days admission to hostel accommodation where appropriate during the initial period of investigation, under Ontario Hospital Services Commission benefits or with other provincial support.

Transportation Services

55 THAT there be developed, in all parts of the province, adequately manned and equipped highway and air ambulance services to permit rapid movement of high risk patients to special treatment units (e.g. neurological-neurosurgical units, respiratory failure units, perinatal centres) or to permit movement of skilled personnel to the patient when this is necessary.

Hostel Services

56. THAT hostel accommodation or similar arrangements be established with Provincial Government financial support, either through new construction or through renovation of existing facilities, in regional and district centres in which highly specialized services are situated.

57. THAT patient stay in hostel accommodation be an insured benefit under the Hospital Insurance Plan, or receive other Provincial Government support.

58. THAT there be a review of hospital procedures with a view to classifying certain medical investigations and surgical operations as suitable for day care practice.

59. THAT comprehensive day care programmes be developed in the various fields of medicine.

Social Services

60. THAT, to consolidate the benefits of highly specialized and other

services to patients, effective social service support to hospital work be planned and provided.

61. THAT, to be effective, social service support, both within and outside hospital, be co-ordinated.

SUB-SECTION B
Recommendations by the Sub-committee on Laboratory Systems
(See report of October 1968—Annex "H")

The Sub-committee report outlines concepts and principles for a system of regional laboratory services. The importance of developing an integrated system to increase efficiency and to provide a framework for more effective services for patients and practitioners is emphasized.